THE PUBLIC INQUIRY INTO THE DEATH OF JERMAINE BAKER

OPENING STATEMENT ON BEHALF OF THE FAMILY OF JERMAINE BAKER

Introduction

1. We make this statement on behalf of the family of Jermaine Baker, and particularly Margaret Smith, his mother; Alexia Demetrio-Baker, his daughter; Eftehia "Tia" Demetrio, Alexia's mother and Jermaine's girlfriend; and Jordan Smith, Jermaine's younger brother.

2. It is fitting that the first witness to this Inquiry will be Margaret. She will place Jermaine and his memory at the heart of these proceedings. She extends her assistance to this Inquiry as Jermaine's mother, as a representative of his family and of his loved ones. She also represents the fundamental and acute public interests in the circumstances in which the Metropolitan Police Service ("MPS") have shot dead another unarmed Black man.

3. Jermaine was born on 16 March 1987; he was 28 years when he died. He was the eldest son of Margaret and the father of two children. He was a devoted, loyal, loving and much-loved father, son, brother, partner and friend; a young man with all the wonder, complexity and potential that involves. Margaret will inform the Inquiry about who Jermaine Baker really was and who he has left behind. She will inform the Inquiry as to how she witnessed Jermaine being prematurely judged, devalued and written off at school, and later, by potential employers, and by society at large. She has never sought to excuse Jermaine for his involvement in the events of 11 December 2015 and makes no attempt to do so before this Inquiry – Margaret says he should have been arrested and prosecuted along with the others involved – but she will provide some context to how he came to be in that position.

4. Margaret is categorically and unequivocally clear that, whatever Jermaine was doing on 11 December 2015, he should not have paid with his life; that his death was entirely unnecessary and unjustifiable; and that it was the result of truly reprehensible failures on the part of the police officers involved. She has been deeply saddened to see in the evidence, an attitude by the officers to Jermaine that tragically mirrored treatment he had suffered in his life. This was not an operation that had regard to the value of Jermaine's life. On the contrary, it was because

these officers diminished and devalued Jermaine that his life was ultimately brought to an end, including by the unreasonable and premature judgment of W80.

5. Tia will also give evidence to the Inquiry on her own behalf and on behalf of Alexia, the daughter she had with Jermaine. She too provides, from her own perspective, a more complete picture of Jermaine than that told by his involvement in the events of 11 December 2015. She knew him as a sweet, funny, and caring young man who became her soulmate, and in time a loving and devoted father to their daughter. She will explain the loss suffered by both her and Alexia, and the way in which the legal processes over the last five and a half years have stood in the way of their ability to process that loss and come to terms with their grief. Alexia is an intelligent, inquisitive and engaged child; at the age of eight she has many questions about Jermaine's death, but she is of course unable to understand fully the events that have led to her growing up without a father. That learning will be a lifelong process for Alexia. Tia seeks to impress upon the Inquiry the vital role it will play in that process; as Alexia grows and develops so will her questions about her father's death and it is to this Inquiry's report that she will look for answers.

6. The family acknowledge the recognition that the Chair and the senior Coroner before him have given to the importance and complexity of the issues they have been called upon to examine. The family's commitment to assisting the Inquiry is also a reflection of the profound importance of these matters beyond their personal unbearable grief.

7. The family seeks answers to the most fundamental issues regarding the loss of Jermaine.

    - What was the plan to ensure his *safe* arrest?

    - Despite the highly resourced and technically sophisticated operation and the multiple opportunities afforded from the outset and right up to the moment the officers deployed from their vehicles to challenge him, was there in fact absolutely *no* planning to ensure his safety in arrest?

    - Was the MPS blinded to Jermaine by the desire to secure convictions of others, serious criminals who had put him in that car that morning but who were themselves nowhere near it?

- How on earth did Jermaine come to be shot dead when he was not carrying a weapon, when there was no gun within reach?

- How did W80, a highly trained firearms officer, a firearms instructor, conclude that Jermaine was reaching for a gun when he had not even given Jermaine time to comply with his instructions and W80 had himself barely had time to assess the situation?

- Is the reality that W80 never did come to that conclusion?

- Is the reality that W80 has constructed an explanation for these events from what he might wish to be true not from the truth of what occurred?

- Has W80 relied upon his training to put forward words of justification well knowing that they would be sufficient for him to escape the reach of criminal sanction?

8. The family have been searching for answers to these questions for five and a half years. They have faced many obstacles. They were incensed by the Commissioner of the Metropolitan Police's ("the Commissioner") decision to permit Detective Chief Inspector Neil Williams - an absolutely central character in this Inquiry - to retire at a time when he was being investigated by the Independent Police Complaints Commission ("IPCC") for serious failures in his management of the operation. They are incensed that the gross misconduct proceedings against W80 have become mired in litigation - litigation instituted by W80 but entirely supported by the Commissioner - and incensed that W80 is currently discharging a firearms training role; a role in which he is called upon to mentor and educate future generations of MPS firearms officers. In these respects, the Commissioner has demonstrated to the family that she is not at all interested in holding her officers to account either to their Code of Ethics or the rule of law. She is unwilling or incapable of challenging the culture of institutional defensiveness and impunity that has pervaded firearms policing for decades.

9. On the family's behalf we emphasise that this process must begin with searching scrutiny of the circumstances of Jermaine's death *and* include the identification of failings and lessons that must be learned. The family looks to this Inquiry to be robust and fearless in its investigation so that its findings as to the circumstances of Jermaine's death and the derelictions of duty and responsibility that caused or contributed to it are reliably established. They look to this Inquiry to challenge, as it must, the complacency that suffused this operation and the firearms orthodoxy that operates as a barrier to meaningful change. As importantly as the duty of the

Inquiry itself to act without fear or favour, the family look to the Commissioner to own her responsibility for Jermaine's death and her personal responsibility to effect necessary change.

10. In these opening remarks we address:

    (a) The legal framework.

    (b) The MPS' duty to plan and execute firearms operations so as to proactively safeguard life and minimise the risk to life to the greatest extent possible: the requirements of Article 2.

    (c) The issues that the Inquiry will need to consider:

        (i) Decision making.

        (ii) Record keeping.

        (iii) The SFC, TFC and TACAD responsibilities.

        (iv) Management of information on the morning of 11 December 2015.

        (v) Strategic, tactical and operational decision making on the morning of 11 December 2015.

    (d) The fatal shot.

    (e) The Commissioner's position in relation to this Inquiry.

The legal framework

11. It will appear dry to move now to consider the legal framework within which this Inquiry will draw its conclusions including the Article 2 jurisprudence, the standard of proof and the test for self-defence. But these matters are hugely important to how the Inquiry must approach its task and we want to make plain at the outset what in our submission the law requires. For this reason, we mention these issues now but will address them more fully in our closing submissions.

Narrative conclusions

12. In fulfilling the purpose set out in his terms of reference, the Chair is requested to set out a narrative as to when, where, how and in what circumstances Jermaine came by his death so as

to ensure that this Inquiry discharges all the functions of an inquest. Those functions include the drawing, where appropriate, of critical and judgmental conclusions including with regard to the legality of W80's actions in particular.

Article 2

13. As this is an Inquiry, the family does not put a "*case*" but rather seeks consideration of the central issues of concern. On the evidence considered to date there are substantive questions as to the entirety of the policing operation that led to Jermaine's death and we commend the Article 2 principles as providing a framework for consideration of those issues.

14. Article 2 imposes an obligation of *"absolute necessity"* upon state agents in their use of potentially lethal force.[1] That obligation requires the State to ensure that firearms officers are trained to assess the absolute necessity of their resort to potentially fatal force and to have due regard to the pre-eminence of respect for human life as a fundamental value[2]. Further, the State is obliged to ensure that the planning and operational phase of a police firearms operation is undertaken so as to minimise, to the greatest extent possible, risks to life and to ensure clear regulation and caution in the use of weapons.[3] All feasible precautions in the choice of means and methods must be taken, and alternative non-lethal solutions considered.[4] It follows that a failure adequately to vet a police officer's suitability to be issued with a firearm amounts to a violation of Article 2.[5] The case law of the European Court of Human Rights ("ECHR") has established an obligation of strict proportionality in the resort to potentially lethal force and accordingly, an obligation to establish an appropriate administrative framework defining the limited circumstances in which police officers may use force and firearms, in light of the relevant international standards.[6] The national regulations must be sufficiently robust to protect against avoidable accident.[7]

15. Thus, this Inquiry must scrupulously examine whether the operation was planned and controlled in compliance with the principles derived from the Article 2 jurisprudence and

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[1] This requirement is explicitly stated within Article 2 but see also, *McCann and others v The United Kingdom* (1996) 21 EHRR 97.

[2] Nachova and others v Bulgaria (2006) 42 EHRR 43

[3] Mc Cann, Ibid [212].

[4] *Finogenov v Russia* (Applications 18299/03 and 27311/03) at [208] and *Bektas v Turkey* (Application 10036/03) at [57], [62].

[5] See for example, Gorovenky and Bugara v Ukraine 12 January 2012 and Gorgiev v The Former Yugoslav Republic of Macedonia 19.04.12

[6] Markaratzis v Greece (50385/99 [57 – 59], Wasilewska and Kaluca v Poland 23 February 2010 and others.

[7] Markaratzis at [58].

specifically the respect for *all* life as a fundamental human value. We place particular emphasis, in the context of this case, upon the obligation to protect against avoidable accident.

Standard of proof

16. There is now a settled approach to the standard of proof in an inquiry, most particularly, one concerning the conduct of agents of the State resulting in the death of a civilian. A flexible and variable standard should be applied. The Inquiry should start - in making its determination of the facts - by applying the civil standard but should record the level of satisfaction which the chair finds is established in relation to any finding of fact. Thus, if Sir, you are not just satisfied on the balance of probabilities, but are also sure of a particular fact, you should say so.[8]

Test for self defence

17. The question whether W80's resort to lethal force was justified is answered differently according to the context. For the purpose of the civil tort of battery, the necessity to use force is judged on the facts as the person who used force believed them to be even if he was mistaken, but only to the extent that the mistaken belief was reasonably held.[9] By contrast, as you well know Sir, as a matter of criminal law if the force is necessary when judged against an honestly held belief, then even if that belief is *not* reasonably held, it will not constitute a crime. As the judicial review brought by W80 against the IOPC has demonstrated, if the question is being asked in respect of police misconduct proceedings its answer is governed by the Code of Ethics, and is different again, determined by neither the criminal nor the civil law tests but by whether the use of force was *"necessary, proportionate and reasonable <u>in all the circumstances</u>"*.[10]

18. This Inquiry has been constituted in place of an inquest. It is, therefore, the means by which the state discharges its investigative obligation under Article 2. The investigation must be effective in the sense that it is capable of leading to a determination of whether the force used was or was not justified in the circumstances[11] and whether there were systemic or operational failings, and to the identification and punishment of those responsible.[12] Proper inquiry into the circumstances of the death necessarily requires consideration of whether the force used on

[8] For a comprehensive discussion of the practices of relevant Inquiries see §§1.34 - 1.49 of the Anthony Grainger Inquiry Report.
[9] Ashley v Chief Constable of Sussex [2008] 1 AC 962
[10] *R (W80) v Independent Office for Police Conduct* [2020] EWCA Civ 1301 (emphasis added).
[11] *Kaya v Turkey* (1999) 28 EHRR 1, at [87].
[12] *Ogur v Turkey* (21594/93) at [88].

Jermaine was legitimate and in accordance with the standards of professional behaviour.[13] The reasonableness of W80's belief is plainly a matter of very great significance to the public, to the family, to the Commissioner and to this Inquiry. There is and can be no judicial forum better equipped to answer it than this Inquiry. It is submitted that were the Inquiry after 8 searching weeks, to fail to answer the question whether W80's mistaken belief that Jermaine was making for a weapon reasonably held, it would have failed to discharge its primary duty as a full fact-finding inquiry, would fail to discharge its terms of reference and to meet all the functions of an inquest. As such this Inquiry should consider *all* the circumstances including the circumstances judged objectively.

19. In summary on this aspect, we invite the Chair to make the following findings of fact:

    (a) Did W80 have an honest belief that Jermaine was about to attack himself or others?

    (b) If "*yes*", was the perceived threat such that it was then reasonably necessary for him to shoot at Jermaine?

    (c) If "*yes*" to (a) was W80's honest belief a reasonable one for him to have held?

The open justice principle

20. We acknowledge the significant industry that has been brought to bear by the Inquiry Legal Team in making available a substantial volume of relevant documentary evidence. Such disclosure is of course necessary to facilitate our client's effective participation in these proceedings and is itself a requirement of the investigative duty under Article 2.

21. We also acknowledge with realism that the concealing of evidence behind redaction and the hearing of evidence in closed sessions - from which the family and we as their representatives will be excluded - is a legal necessity in certain clearly defined circumstances. The Inquiry will appreciate its obligation to ensure in the context of meeting those legal necessities that there must be the absolute minimum interference with the open justice principle not least because it is W80's account that it was his belief as to the intelligence picture combined with Jermaine's actions (which we now know to be entirely innocent) that caused him to shoot to kill. Thus, the intelligence picture, how it was evaluated and disseminated, is at the very centre of everything this Inquiry is called upon to investigate.

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[13] *R(Carol Pounder) v HM Coroner North And South Districts Durham and Darlington* [2009] EWHC 76 (Admin) at [73].

22. We ask the Inquiry to adopt a rigorous practice of ensuring that all evidence that can lawfully be shared - whether initially heard in closed session or initially the subject of redaction - is shared no matter how apparently insignificant. We ask the Inquiry to keep such redactions as it has approved under review as the evidence emerges and potential shifts in the public interest balancing exercise occur. We ask the Inquiry to provide the core participants with thorough and careful gisting wherever possible to minimise the extent to which the family is shut out from evidence of the gravest import. We are concerned that to date there is a great deal of information either received or generated by the MPS which has not been provided in gisted form. We have written to the Inquiry expressing our concerns.

23. We know that the Inquiry recognises the onerous responsibility it faces in respect of the closed evidence. Indeed it was to afford the Inquiry the ability robustly to test the evidence in closed hearings that this public inquiry was established.

24. Much of that closed evidence will be heard at the outset. We take this opportunity therefore to identify key issues that the family considers must be explored in those closed sessions:

    (a) The Inquiry must identify each and every piece of information/intelligence that was either generated or received by the MPS, the date it was created or received and the form in which it was first recorded.

    (b) It must determine the reliability of the intelligence.

    (c) It must trace each such piece of intelligence/information as it was developed and was disseminated to compare its raw form against its later iterations.

    (d) It must determine whether alterations to the information/intelligence as it was disseminated and re-disseminated degraded the quality of the intelligence.

    (e) If the Inquiry finds that the quality of the intelligence was degraded, it must determine whether this was for legitimate law enforcement purposes, such as protecting sources, or complying with statutory obligations, or whether it was due to something else, and in particular a lack of care and/or compliance with protocol.

    (f) The Inquiry must identify the precise information/intelligence made available to the Tactical Firearms Commander ("TFC") and the officers he commanded within the Specialist Crime and Operations Directorate ("SCO7") and the Specialist Firearms

Directorate ("SCO19"), including the precise form of words in which such intelligence was provided.

(g) The Inquiry must determine whether the resources of the Covert Intelligence Directorate ("SCO35") were fully and adequately exploited.

(h) The Inquiry must determine whether the information/intelligence was adequately evaluated in relation to its true meaning including how information emerging from the operation and other sources bore on that meaning.

(i) The Inquiry must determine whether the information/intelligence was properly actioned, that is, whether appropriate actions were identified to be taken in light of the intelligence when considered in the context of the information emerging from the operation and other sources. A good example which relates to intelligence which an actually be dealt with in open, is what action was proposed to be taken to either confirm or contradict the intelligence received on the morning of 11 December that those planning the breakout had been unable to source a real firearm.

The issues that the Inquiry will need to consider

25. In what follows we focus on what the family have identified as the most important issues that the Inquiry must address. But we also pose a series of broader, significant questions that must be answered.

Decision making

26. A critical aspect of the Inquiry's considerations will be scrutiny of the roles of the TFC, former DCI Neil Williams and Strategic Firearms Commanders ("SFC"), Detective Superintendent Craig Turner who collectively held overarching tactical and strategic decision-making responsibility. They are both central figures in this Inquiry.

27. We encourage the Inquiry in its consideration of this and other aspects of the decision making to have close regard to the National Decision-Making Model ("NDM") and in particular the critical importance of reassessing policing situations in a continuous cycle driven by new information.[14]

[14] See DCI Williams entry to his log at 06:45 *"NDM reviewed no change"* [IPC15/1] and DCI Keely Smith's similar entry to her log at 07:00 [IPC149/53].

28. The TFC's decision making was – it would appear – disastrously compromised by a flawed investigative strategy, namely DI Murray's plan to permit the criminal enterprise to run rather than take steps to disrupt it in the interests of wider public protection from the Tottenham Turks Organised Crime Group ("OCG") and the TFC's own failure to challenge that strategy. This plan was also approved by the SFC, Detective Superintendent Craig Turner and the responsibility for it ultimately rested with him.

29. The Inquiry will need to identify at what stage in the planning process the key decision makers had settled on a plan with a likely end point of an armed intervention; an armed intervention on whoever it was who was involved on the day in attempting to mount the escape.

30. As the experts Ian Arundale QPM and Colin Burrows QPM note in their report, the evidence suggests that by as early as 10 November 2015, when the first planning meeting took place, the basis of the operation had been discussed, if not agreed, and provisionally scoped. The Inquiry will have to determine whether in settling on and authorising this plan with that likely end point, D Supt Craig Turner, as SFC, gave overriding weight to the desired investigative and criminal justice outcomes and failed to discharge his critical role of ensuring that the positive obligation to protect life took precedence. It will have to consider whether former DCI Neil Williams as line manager of DI Murray had the necessary separation from the investigation to discharge his function as the TFC, or whether, like D Supt Craig Turner, his focus was also overwhelmed by the desired investigative and criminal justice outcomes.

31. From as early as 10 November 2015 - when the end point of arrest was firmly in contemplation - it was clear that any such arrest was liable to involve firearms either on the part of the police or on the part of both the police and the conspirators. The commanding officers had before them a period of nearly five weeks to strategise and plan so as to minimise the obvious risks arising from the armed confrontation that marked the settled likely end point of the operation.

32. The Inquiry will have to consider whether, having settled on armed confrontation as the likely end point, former DCI Neil Williams failed to ensure - with his tactical advisor, S48 - that the plan including with respect to that end point, was developed and coordinated so as to minimise the risks associated with it and whether there was a lack of strategic oversight of that plan from D Super Craig Turner. This will require detailed scrutiny of the *planning around the possibility of an armed interception*. The Inquiry is thus asked to determine the following issues.

- Whether the risks posed by such an interception were identified and considered as part of the planning process from the moment when armed arrest was identified as a possible or probable end point?

- Whether all potential tactical options to achieve that end point, including contain and call out, were systematically worked through and the rationales for selecting or discounting any option explicitly explored?

- Whether intelligence/information was properly evaluated and gaps identified which bore on the risks associated with any particular option? Whether measures were identified to fill those gaps? Whether, in accordance with the NDM, this process was repeated as the intelligence picture changed including as the events unfolded on the morning of 11 December 2015?

Record keeping

33. In relation to decision making generally, the Inquiry will need to consider not only the quality of the decision making but the quality of the *process* followed in arriving at critical decisions. This will entail scrutiny of the records and decision-making logs of the individual commanders and as importantly - the absence of any such records. It will require careful examination of the context in which records were made (or not) and the quality of such entries as have been made.

34. The recording of information is of critical importance.

- Were the records maintained by the firearms commanders and their Tactical Advisor ("TACAD"), S48, adequate and fit for purpose?

- Why did former DCI Williams not maintain any record of his planning meetings on 10 November and 3 December 2015? How did former DCI Williams arrive at the conclusion that there was not even a *requirement* for him to record critical meetings?

- Why was there a failure on the part of the SFC and TFCs to record meetings and decisions?

- Why was the requirement not complied with by the SFC, TFC and TA that all plans be documented, including options rejected or progressed, together with the reasons why such conclusions were drawn and by whom?

- Does the attitude to record keeping indicate a group of officers who failed to grasp the importance of a methodical and professional approach to the significant responsibilities they held?

- Was there a loss of accountability and transparency?

35. Insofar as records were not kept of crucial meetings the Inquiry must take a sceptical approach to attempts by witnesses to fill in evidential gaps, especially, where this is not supported by the records that were actually made.

The SFC, TFC and TACAD responsibilities

36. The SFC, D Supt Craig Turner was the officer in overall strategic command with responsibility and accountability for directions given. It was his duty to *"ratify the working strategy having reviewed, and amended if necessary, the threat and risk assessment and working strategy developed by the TFC"* and it was his responsibility to *"ensure the resilience of the command structure and the effectiveness of the TFC."*[15]

37. Firearms doctrine placed certain mandatory obligations upon former DCI Williams as the overarching TFC in the discharge of his responsibility to develop and coordinate the tactical plan, including obligations to assess and develop the available information and intelligence, to review and update the tactical plan and ensure that any changes were communicated to the Operational Firearms Commanders ("OFCs") and where appropriate, the SFC.[16] The MPS Police Use of Firearms and Less Lethal Weapons - Standard Operating Procedures ("MPS SOP") placed a mandatory obligation on him to ensure *"that as far as time permits, information and intelligence is appropriately assessed, graded and where possible, verified"* and *"information and intelligence should be passed to officers as necessary for the roles that they are performing"*. The Approved Policing Practice - Armed Policing ("APP-AP") also emphasises the importance of ensuring that *"a full, current and accurate intelligence picture is maintained and that this is conveyed as appropriate to those involved."*

38. The TACAD, Inspector S48 was personally responsible for the validity and reliability of the advice he gave albeit that the responsibility for the use of that advice lay with D Supt Craig Turner and former DCI Neil Williams. It was his responsibility to advise as to the capabilities and limitations of the Authorised Firearms Officers ("AFOs") and other police resources being deployed, the

[15] APP-AP, Command module §2.1
[16] Ibid at §2.2

implications of any tactical parameters which had been set, the available tactical options, suitable contingencies and the implications of each tactical option.

39. It is by refence to those mandatory obligations in the context of the questions we have just posed that we invite the Inquiry to scrutinise the SFC, TFC and TACAD decision makers' conduct and it is in their discharge of those mandatory obligations that we consider the evidence to reveal breath-taking complacency on their part and disastrous incompetence. Some of the key questions that must be answered given their respective roles are as follows:

- Whether the SFC's approach was insufficiently intrusive in the context of the real risks associated with this operation and the extent to which he bears the ultimate responsibility for the investigative strategy overwhelming consideration of the lethal risks.

- Did the SFC fail to undertake any or any adequate strategic risk assessment and fail to balance the potential public protection gains (from permitting the criminal enterprise to be progressed) against the risks inherent in a MASTS intervention against unknown subjects at an inherently unsuitable location?

- Was there a failure to comply with the APP-AP and MPS SOP including the requirement to separate the functions of the firearms commanders from the role undertaken by the SIO (who had been line managed by the TFC in the policing of the Tottenham Turks OCG for some 7 years) with the consequence that the imperatives of the investigation overwhelmed the firearms commanders' decision making particularly with regard to the appropriate management and control of risk?

- Did the SFC fail to set, review, communicate and update the strategy based on threat assessment (including in the operational phase of the deployment)?

- Whether the pursuit of evidential "*tipping points*" - specifically those associated with offences concerning the possession of firearms - influenced the chosen firearms tactics and ultimately led to an extremely high-risk confrontation between the AFOs and the occupants of KM13 YPT.

- Whether the pursuit of evidential "*tipping points*" in the context of the developing intelligence picture caused former DCI Williams to lose sight of the operation's

strategic objectives and whether his command of the operation lacked accountability to the parameters of its authorisation.

- Did the decision to increase the short-term risks associated with the tactical arrest plan with the intention of reducing the long-term risk to the public lack rational justification?

- If it did not lack rational justification, were the associated short-term risks - in particular of an armed interception - adequately identified and mitigated?

- How were the obvious risks associated with an armed confrontation between the MASTS officers and the occupants of KM13 YPT assessed throughout the period leading to 11 December as low?

- How and why were the heightened risks associated with a loss of control over the suspects and lack of knowledge of the capabilities and intentions of the occupants of KM13 YPT not identified in advance and made the subject of relevant contingencies and/or tactical parameters?

- Was there adequate consideration of the evidential tipping points and/or a failure to identify that sufficient evidence had been marshalled *before* 11 December 2015?

- Was there any or any sufficient re-consideration of the strategic objectives when it became apparent that those involved would not be relying on real firearms and there was therefore no prospect of taking firearms off the street?

- Was the reality that – properly analysed – the risks associated with the working strategy were so serious as to necessitate a complete disruption of the escape plan whether by organising a video hearing for 11 December 2015 or otherwise?

- Was there sufficient exploitation of the available conventional and non-conventional[17] means of maintaining control over the suspects including Ozcan

[17] Aerial platforms, thermal imaging cameras, CHIS, OCG mapping, development of subject profiles, the full range of technical and manual evidence gathering tools to be deployed within observation posts, local authority CCTV, etc.

Eren and Sinan Ozger, the subject vehicle, KM13 YPT (including significantly who and what had gone in or out of that vehicle)?

Management of information on the morning of 11 December 2015

40. By the morning of 11 December there had been a woeful failure to assess the risk of an armed arrest. There had been a woeful failure to work through at all, let alone systematically, the available tactical options. There had been a woeful failure to identify and plug intelligence gaps that would have assisted in minimising the risk. Inevitably therefore there was a failure to forward plan to ensure the continued assessment of the risk of armed intervention, to ensure that the intelligence requirements of the operation were identified and addressed, to ensure that additional information was promptly and comprehensively evaluated and the strategic, tactical and operational plans adjusted accordingly.

41. The first and most glaring failure on the morning of 11 December relates to the gathering, handling and dissemination of intelligence about whether those engaged in the escape plan would have access to real firearms. The family is not privy to the intelligence but see from the IPCC report[18] that intelligence was being provided in the days and weeks prior to 11 December that those planning the escape "*were attempting to source a real firearm, but despite numerous attempts this was not successful*". The IPCC was unable to establish exactly what form of words was used to disseminate this information (another instance of poor record keeping). However, from a review of the FA2, the IPCC concluded that information similar to this had been disseminated by some means. It would appear from their analysis that on the morning of 11 December, FE19 passed new intelligence to former DCI Williams in addition to what had already been received about the difficulty in sourcing a real firearm, that those planning the escape attempt had not been able to get a real firearm and only had access to a replica that looked extremely real.[19] On the information we have considered this was high grade and confirmed intelligence.

42. Moreover, the CTSFOs had already been briefed at the 3 and 5 am briefings that the offenders *would* have access to firearms. V64's briefing note states *"the intelligence suggests that those seeking to carry out this offence <u>will</u> be in position of firearms and other weapons … it is assessed that firearms <u>will</u> be used to effect the escape"*. How this message came to be conveyed is itself a matter for exploration. But given the intelligence subsequently received by former DCI

[18] Para 197-8.
[19] Para 201.

Williams which contradicted this message, why did he decide to reinforce the message by directing that CTSFOs be informed that the intelligence picture was that any offences "*would be firearms enabled"*? In this context the Inquiry will wish to give careful scrutiny to the handling of the audio probe product including consideration of its content (by decision makers including former DCI Williams in particular), and its potential to offer extremely valuable corroboration of intelligence from other sources. A central plank of the Inquiry's work will therefore be achieving an understanding of former DCI Williams' decision making in respect of these critical pieces of intelligence including decisions made in relation to the sharing of information with the CTSFOs.

43. In relation to the handling of information the Inquiry is asked to identify:

- A clear and complete audit trail of the precise content and time when the relevant intelligence came across to officers working within SCO7 and SCO19.

- Whether there was a significant delay in former DCI Neil Williams becoming aware of this intelligence and if so, why?

- The circumstances in which key briefings were incomplete and inaccurate and were not attended by all relevant personnel.

- Whether the intelligence picture as to the OCG's reliance upon firearms was overstated particularly in the "*firearms enabled"* message communicated from central control as an update to Team 6 – the team tasked with decisive action on KM13 YPT– at 07:29.

- Why did former DCI Williams record in his log, "*intelligence suggested that they will have* *__at least__* [20] *an imitation firearm at the time of the offence*"?

- Did former DCI Williams inform D Supt Craig Turner and S48 about this intelligence?

- What if anything did DCI Williams say to those listening to the probe to ensure they listened carefully for references to the possession of firearms?

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[20] Emphasis added.

- Why was the intelligence regarding reliance upon a replica not circulated to the armed officers who were responsible for performing the strike on KM13 YPT?

- The circumstances in which it became apparent that the rewind facility was not operational (and if not prior to the strike, why this did not become apparent given the centrality of this source of information).

- The circumstances in which officers advanced diverse accounts as to how the intelligence picture was agreed (or not agreed) whether by reference to a "*form of words"* or not, and disseminated.

- Whether there were failures adequately to differentiate between information and intelligence and to evaluate both.

Strategic, tactical and operational decision making on the morning of 11 December

44. As we have noted in relation to the long-term planning of this operation an overriding concern for the family is that former DCI Williams, who was simultaneously the TFC and the line manager of the SIO, prioritised evidential sufficiency for the purposes of the prosecution of members of the Tottenham Turks OCG over life safety. That concern is even more acute in relation to the activities on the morning of 11 December. As the planning phase came to an end and the operational phase began, the window of opportunity to remedy any failures to plan and minimise the risks of an armed intervention began to diminish.

45. In a statement dated 16 December 2015, former DCI Williams informed the IPCC that in considering the available tactical options, *"effective control of the Audi was paramount as this provided the optimum opportunity to close intelligence gaps and conduct any operation safely*", that the success of the intended operation depended upon *"effective control of the Audi"* being *"obtained and maintained"* and that although it was difficult to be precise in his discussions with the SFC with regard to the details of the operation and the tipping points, *"it was ultimately about* CONTROL.[21] *If at any stage I was to take the view that I had insufficient control to maximise the safety of all parties I would revert to overt protection [of the prison van]...".*[22]

[21] Emphasis original.
[22] MPS71/3

46. Yet the evidence reveals monumental failures to gain *meaningful* control over key components of the criminal enterprise throughout the morning, not just for the purpose of advancing the criminal investigation but more importantly for the purpose of minimising the risk of any ultimate arrest by armed officers. Thus, the whereabouts of the primary suspect, Ozcan Eren, was unknown. While there were cameras and surveillance officers located at the original position of KM13 YPT off Eastern Road, similar resources were not available in Bracknell Close and this loss of control resulted in the arrest operation being deprived of critically important information:

(a) Whether the windows were tinted? There had been ample opportunity to ascertain this from the moment the probe and location devices had been installed on 8 December to the moment the CTSFO's deployed to extract the Jermaine and his fellow occupants at 9am on 11 December.

(b) The true number of occupants in the vehicle? Team Bravo, the CTSFOs deployed on KM13 YPT, were led to believe that there were possibly four occupants in the Audi.

(c) Whether there was any visibility into the vehicle?

(d) The position in which the vehicle was parked relative to other vehicles and members of the public? This information was plainly of huge importance in managing the risks of an armed intervention. Those risks obviously varied to the extent that members of the public were present, and their presence was plainly a significant factor in planning how to effect the arrests. The ease of access to the vehicle in order to perform an extraction was also of obvious significance. If there were obstacles in the way of officers getting to the occupants and extracting them, this plainly had a bearing on the risks and ultimately on extraction as an appropriate tactic.

47. It must be kept in mind that by the time state amber was called the vehicle was known to have been stationary for 50 minutes in a position that it was highly foreseeable would be its resting place until the prison van arrived. From the probe in the vehicle, it was possible to pick up that there were only three occupants. From the probe in the vehicle, it was possible to identify that the report from the surveillance team about two more people probably getting in at around 7.40 was in fact two of the occupants getting back into the car having got out to relieve themselves. From the probe it would have been possible to rectify the mistaken belief that the possible third eye spotted by surveillance had alighted from the vehicle. From the probe it

would have been possible to acquire critical confirmation that the occupants were not armed with a real firearm but with a replica.

48. The Inquiry must ask whether these questions remained unanswered even though every reasonable opportunity to review the operational plan was exploited or whether in reality nothing was done to plan so as to minimise the risk to life arising from performing an extraction of the occupants of KM13 YPT. The family strongly believe that the firearms commanders pressed on with this operation despite the gaping holes in the intelligence picture because they were narrowly focused on the criminal investigation and blinded by its imperatives. They did not take the multiple opportunities available to them to gather intelligence relevant to the contemplated end point of arrest. Former DCI Williams apparently considered the audio feed to be of *"paramount importance"* in filling intelligence gaps, minimising risk and in his operational decision making more generally.[23] Yet he does not appear to have personally listened to that output and certainly did not evaluate the information emerging from it. The discussions of the occupants relating to their possession of firearms had not been carefully scoured to see whether they confirmed the intelligence passed to former DCI Williams by FE19 that they would only have an imitation firearm. The occupants had not been identified and there was no intelligence to suggest who they might be, nor with regard to their capabilities.[24]

49. It is in the context of the failure to obtain critical information and intelligence relevant to planning for the arrest, that the tactical option of contain and call out and the failure to adopt it, must also be considered. While the intelligence strongly suggested that the occupants were armed only with an imitation firearm – judged conservatively that is, on the basis that the intelligence could be wrong – the officers should not have approached KM13 YPT. The vehicle was capable of being contained at its location. The tactical option of calling out the occupants would have afforded the AFOs the ballistic protection of their own vehicles. It would have afforded the AFOs an opportunity to ensure that all members of the public, in particular, the builders immediately in front of the vehicle could be moved to safety. It would have been known that an extraction tactic faced the obstacle of a vehicle being parked very close to the offside of KM13 YPT. It would have afforded an opportunity for a lead CTSFO to issue clear and uniform instructions to the occupants. As matters stood, even without the intelligence that could and should have been gathered over the previous hour the vehicle sat in Bracknell Close, it would have afforded an opportunity to gain intelligence regarding who was in the car

[23] DCI Williams statement dated 16 December 2015.
[24] See Ms Blakeney's log at 06:40 [IPC251/4].

(including numbers); to fill that highly significant intelligence gap and afford the occupants an opportunity to surrender.

50. In the event the strike on KM13 YPT was chaotic and highly dangerous; officers approached the vehicle containing an unknown number of subjects, who they were unable to see, all believed to be armed and prepared to deploy their weapons, in extremely close proximity to the subjects, creating obvious risks including the potential of physical confrontation. They did so shouting numerous and different instructions. S111 and W80 were confronted by a very narrow field of operation because of the adjacent car, for which they were wholly unprepared. The attempt by S111 to smash the front passenger window appears to have been particularly poorly considered (S111 did not have an "*appropriate device")*; the attempt was unsuccessful, and W80's firearm discharge followed less than three seconds later.

51. We ask this Inquiry to scrutinise whether Jermaine died in the course of an operation that was not under effective control, that was botched and unprofessional from its very inception. The critical issues include:

- Whether the available sources of information and intelligence including notably, the probe, were exploited for the purposes of discharging the commanders' responsibility to proactively safeguard life and minimise risk to the greatest extent possible (as opposed to exploitation of information sources in pursuit of evidential tipping points).

- How was it possible that by the time the operation was moved to state amber so much remained unknown about the vehicle, its occupants and what if any weapons they had brought into the vehicle with them?

- What were the causes for the divergence between the front line AFOs' perception of risk (that is, an incredibly dangerous high-risk operation) and that of their commanders (low risk) and the contribution that this divergence played in the catastrophic outcome to the operation?

- How was anyone inside KM13 YPT to know what they were supposed to do?

- Where was the planning for how the officers would communicate with the occupants to prevent confusion and ensure compliance?

- Was there sufficient exploitation of opportunities to determine who was in KM13 YPT on the morning of 11 December and to acquire other information and intelligence relevant to assessing the appropriate tactical plan.

- What plans were in place to keep control of the vehicle in the event that it moved away from the Eastern Road "*plot*" before mounting the escape attempt?

- What attempts were made to use the probe in order to gather key intelligence relating to the vehicle after it had left Eastern Road?

- Did the SFC fail to discharge his responsibilities during the course of the morning of 11 December 2015 and if so, what contribution did the absence of strategic oversight make to the effective management of the risks to life? To what extent does responsibility rest with him for failing to ensure that the the intended operation did not breach the principle of "*absolute necessity"* in the resort to potentially lethal force?

- Do the SFC and/or TFC bear responsibility for permitting an unacceptable degree of risk to those who lived or were working in Bracknell Close that morning, by permitting the OCG to bring together individuals and potentially serious firearms and to engage those individuals in a high-risk MASTS extraction?

The fatal shot

52. This Inquiry's duty is to grapple with complex and difficult questions. None is more complex or difficult than why W80 shot to kill Jermaine Baker. To the extent that W80's history has been disclosed to the family, it is understood to be one of a front-line officer, one who left the front line, who took up a training role, who returned to the front line and within a few weeks killed an unarmed man, who thereafter absconded from his profession and from his family, who caused a man hunt and who was found sleeping rough and suicidal. However unpalatable and uncomfortable these facts are; the family rightly seeks a full investigation of them. That must entail full disclosure of every relevant element of W80's personnel history; the events surrounding his transfer to a training role, his conduct within that deployment, his suitability to be deployed on 11 December and ultimately, his suitability for his current role.

53. At its highest W80's justification for his resort to lethal force was his apprehension that Jermaine *might* have been reaching for a concealed weapon in the context of his having been

informed - erroneously - that there was a firearm in the Audi. What this Inquiry will be compelled to find beyond any doubt is that *if* W80 did form that impression, he was wrong. Jermaine was not reaching for a firearm in his bag; there was in fact no weapon in his bag.

54. The Inquiry will wish to consider the adequacy of the justifications advanced by W80 and it must also consider whether W80 has advanced a full and honest history of the events. It must conduct that investigation without benefit of any visual recordings of the events, without data having been recorded to an incident data recorder ("IDR") and without recordings of the audio communications from control and between officers. We invite the Inquiry to consider whether there exists any legitimate explanation for the strike not having been recorded whether to an IDR, Body Worn, dashboard or aerial cameras and for the decisions not to record telephone communications to and from C3000 and between officers on the ground.[25] We note in this context that prior to May 2014 the MPS announced that SCO19 officers would in future deploy with video cameras.[26]

55. The Inquiry will need to carefully review the audio recordings from the inside of the Audi to establish whether W80 did - as he says - shout repeatedly for Jermaine to put his hands on the dashboard or whether the only instructions issued at that time were to *"put your hands up".* [27] The trajectory of the fatal shot is consistent with Jermaine's compliance with that instruction. The Inquiry will consider whether W80 denied Jermaine an opportunity to comply with the instructions he was being given. The audio reveals that the time frame within which W80 reached his decision was extremely short, a mere two to three seconds from the last strike on the passenger front door by S111 and the shot by W80 through that door which he had first to open.

56. The Inquiry will also consider the chaotic and inherently dangerous nature of the strike overall. Surely the likelihood of the subjects delaying their compliance with instruction by a matter of seconds must have been considered; the possibility of a fainting or other involuntary movement must surely have been considered; why then was the risk assessment so low; why were actions not taken to minimise those risks?

The Commissioner's position

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[25] See HHJ Judge Keith Cutler CBE's Report to Prevent Future Deaths following the Inquest touching upon the death of Mark Duggan dated 29 May 2014, concern 6.
[26] Ibid at §91.
[27] [MPS303/1].

57. In submissions dated 10 and 22 January 2020 the family invited the Commissioner to set out her position in relation to Jermaine's death. The Commissioner opposed that proposal on the grounds that there was no power within the proceedings (at that stage, inquest proceedings) to compel her to do so, that setting out her position ran the risk of turning an inquisitorial process into an adversarial one, that it would be premature to do so and that this Inquiry would be sufficiently assisted by her closing submissions[28]. We disagree with the Commissioner's stance in these respects. The Commissioner's opening statement to this inquiry affords her a further opportunity to state what she has learned, what she acknowledges her officers got wrong and how she intends to ensure that the lessons already identified and those emerging from this Inquiry, are truly learned and meaningful change affected. We reiterate our invitation to her to take up this opportunity and to volunteer her position.

58. In this regard the Commissioner has the benefit of informed external scrutiny that has already identified critical lessons. The evidential phase of this Inquiry commences almost 5 years after the IPCC finalised a highly damning report identifying a range of issues with the MPS' decision making on 11 December 2015 at a strategic, tactical and operational level. That learning has now been augmented by the report of Ian Arundale QPM and Colin Burrows QPM; a report which together with its appendices provides a line-by-line critique of the MPS' decision making and again, those criticisms extend from an operational to a strategic level.

59. We note that the Arundale/Burrows Report reflects on the parallels between the manner in which the MPS failed Azelle Rodney in April 2005 and the manner in which it has failed Jermaine Baker in 2015. We welcome the Inquiry's decision to call evidence from Chief Constable Simon Chesterman, the national lead for armed policing and Mark Williams the Head of the Police Powers Unit at the Home Office; it is of critical importance to consider the failure to learn lessons from similar inquests and public inquiries.

60. Beyond the MPS but also of particular relevance is the fatal police shooting of Anthony Grainger on 3 March 2012. In that matter in June 2013 the IPCC also produced a highly critical report.[29] It is material to this Inquiry's scrutiny of the MPS decision making in December 2015 that some two years earlier, the IPCC had identified the following failings of sufficient seriousness and

[28] MPS Submissions on Position Statements dated 12 January 2020 and 3 February 2020.
[29] We do not refer here to HHJ Teague QC's report of the Anthony Grainger Inquiry as those conclusions post-date Operation Ankaa.

causative impact to merit the criminal prosecution[30] of the Chief Constable of Greater Manchester Police:

(a) The choice of a MASTS intervention in pursuit of tipping points without fully considering other options had not met the Article 2 obligation to proactively safeguard life and minimise risk to the greatest extent possible.

(b) The TFC did not explore with the TACAD options that would better minimise the risk to life. The tactics were pre-authorised and were not deployment, subject or situation specific.

(c) Despite the stationary position of the subject car being known to police, the alignment of vehicles selected to execute the strike exposed firearms officers to the occupants of the Audi that could have heightened their vulnerability and perceived risk.

(d) The "*tipping points*" influenced the chosen firearms tactics by directing an intervention based on awaiting evidence rather than alternative options (the more obvious choice was disruption).

(e) The pursuit of "*tipping points*" and working from an overstated intelligence picture led to the selection of a plan (a MASTS intervention) that carried with it a high risk to the life of the officers, the subjects and members of the public.

(f) The intelligence utilised was not sufficiently operation and subject specific.

(g) Briefings had not provided accurate information from the available intelligence as to the nature of the risk posed by the subjects of the operation.

(h) The recording of rationales for decisions and tactical options selected and rejected was poor and not compliant with the then ACPO guidance.

(i) The officer who fired the fatal shot had either ignored information that suggested there were gaps in his understanding of the intelligence picture or had provided inaccurate information to the IPCC in order to justify his subsequent actions.

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[30] Those proceedings were ultimately stayed on the Chief Constable's application as he was unable to rely in his defence upon aspects of the intelligence picture.

61. The parallels from just those headline conclusions are stark and there are also parallels with the learning that should have been embedded following the death of Mark Duggan on 4 August 2011 and which concerned SCO19 officers deploying from what is understood to be the same location as the officers who were deployed on 11 December 2015 that is, "*Quicksilver*" patrol base in Wood Green. On 29 May 2014 just 18 months before the operation that led to Jermaine's death, HHJ Keith Cutler CBE sitting as an Assistant Coroner for the Inquest touching upon the death of Mark Duggan issued his Report to Prevent Future Deaths. He identified that the MPS and SOCA (as the NCA was then known) *"could have reacted better to developing events and used their joint intelligence resources better".* In particular HHJ Cutler criticised the MPS for pursuing a strategy of waiting for Mark Duggan to obtain a gun before stopping him; the imperative of getting guns off the streets should have prompted earlier action to remove them. He made plain that his concern was directed to the MPS and the NCA and remarked:

"No witness from the MPS or SOCA acknowledged any deficiency in planning or the use of intelligence. I am satisfied that, if the circumstances were repeated, they would act in the same way. I do not say that the matters which concern me caused or contributed to Mr Duggan's death. However, if lessons are not learned I believe that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future."

62. The delays between fatal incidents and outcomes from the corresponding inquiries must not be permitted to delay meaningful change. Ascertaining the response of firearms policing nationally[31] to Sir Christopher Holland's 2013 Report of the Azelle Rodney Inquiry, the early IPCC findings in relation to the death of Anthony Grainger and HHJ Cutler's 2014 Report in relation to Mark Duggan is, we submit, an important strand of this Inquiry's work.

63. In our introductory observations we made reference to institutional defensiveness. The time for the Commissioner to adopt a different stance is long overdue. She must now give meaningful reassurance to this Inquiry and to Jermaine's family that the learning from *this* Inquiry will not gather dust along with the other reports to which we have referred. The starting point should be her opening statement to this Inquiry.

[31] As will be appreciated national guidance and doctrine has been developed in firearms policing given the inherent dangers and risks to life and it is not sufficient for the MPS to deny knowledge of serious failings identified in an operation run by Greater Manchester Police.

Concluding observations

64. The family seek full scrutiny, effective lesson learning and the implementation of tangible protections to prevent similar future fatalities.

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