IN THE MATTER OF THE PUBLIC INQUIRY
INTO THE DEATH OF JERMAINE BAKER

BEFORE HH CLEMENT GOLDSTONE QC

MPS SUPPLEMENTARY STATEMENT ON UNLAWFUL KILLING

References to the transcripts of the evidentiary hearings within this document are cited in the format: Day/page/line e.g. 21/1/1-25 = day 21, page 1, line 1 to 25.

I. INTRODUCTION

1. The MPS was surprised to learn that the family submit that the chairman should conclude that Jermaine Baker was unlawfully killed as a result of gross negligence manslaughter by the Tactical Firearms Commander (TFC).

2. In order for a court to safely reach such a conclusion the chairman would have to be satisfied of a number of factors, including that there was exceptionally high culpability by the TFC so as to be criminal, that it was reasonably foreseeable that such a breach would cause death, and that the breach did cause death. The evidence manifestly does not support such propositions. The conclusion is not open to be reached on the evidence that has been heard.

3. The surprising nature of the family's submission is underlined by the following:

   i. Gross negligence manslaughter was not mentioned in opening by CTI or any CP.

   ii. The elements of the offence and the applicable legal principles are not addressed in CTI's note on the law.

iii. Questions of gross negligence and foreseeability of a serious and obvious risk of death were never explored with the TFC in evidence. Whilst there is no duty to "put a case" in inquisitorial proceedings, it is telling that the extremely serious allegation of gross negligence creating a foreseeable risk of death was never put to the TFC (c.f. the position in relation to W80 and unlawful killing).

iv. The TFC was never cautioned during his evidence on either occasion.

v. Concepts of gross negligence were not explored with the experts.

4. No criticism is intended of CTI by the observations at (3)(i) to (v) above. That this has never been raised before is simply a reflection of the fact that the submission is unsustainable.

5. This note will address the applicable legal principles and briefly apply these to the facts of the case. Given that, for the reasons set out at (3) above, the MPS did not anticipate that any CP would suggest this finding is open to the chairman; and given the seriousness of the suggestion, it has been necessary to focus on gross negligence manslaughter. It has not been possible, in the 48 hours available, to respond to all other matters raised by the family in their written submissions. It suffices to note that the MPS stands by its position as set out in its opening and closing statements.

6. The MPS notes that the family has raised a submission that was mentioned in their opening statement, as to whether the chairman should (in effect) determine whether W80 "unlawfully killed" Jermaine Baker by reference to the test in civil law. For the same reasons the MPS gave in its own opening statement, it is submitted that this would not be a proper approach. The MPS briefly addresses relevant legal principles below.

II. GROSS NEGLIGENCE MANSLAUGHTER

7. At paragraph [26] of their closing statement, the family summarise the six elements of gross negligence manslaughter set out in the judgment of the Court of Appeal in *R v Broughton* [2020] EWCA crim 1093 at [5].

8. This paragraph should be considered in full; the judgment provides that each of the following elements must be made out to constitute the offence:

   i) *The defendant owed an existing duty of care to the victim.*

   ii) *The defendant negligently breached that duty of care.*

   iii) *At the time of the breach there was a serious and obvious risk of death. Serious, in this context, qualifies the nature of the risk of death as something much more than minimal or remote. Risk of injury or illness, even serious injury or illness, is not enough. An obvious risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation.*

   iv) *It was reasonably foreseeable at the time of the breach of the duty that the breach gave rise to a serious and obvious risk of death.*

   v) *The breach of the duty caused or made a significant (i.e. more than minimal) contribution to the death of the victim.*

   vi) *... the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.*

9. If the chairman were seriously to consider the question of gross negligence manslaughter, then further guidance would be required on each element.

III. RELEVANT LEGAL PRINCIPLES

10. The MPS of course agrees with the family that the chairman will be well familiar with the law in this area from his (and CTI's) extensive criminal law experience. For reasons of time and brevity, the MPS takes as read the law as set out in the *Crown Court Compendium*, chapter 1 at 19-3; *Archbold* [2021] at 19-122 to 19-125; and *Blackstone's* [2021] at B1.61-B1.66.

11. Whilst it is therefore unnecessary to set out each of the relevant principles, the key points are as follows:

i. EXISTENCE OF DUTY OF CARE

12. The court must be satisfied that a duty of care exists. Whilst the MPS accepts such a duty of care could apply between a TFC and the subjects of an armed operation, the ambit of that duty of care must be carefully defined and cannot simply be assumed.

13. In his ruling as to why gross negligence manslaughter would not be left to the jury in the *de Menezes* inquest, Sir Michael Wright concluded that there was a duty of care upon those who commanded the operation, but one which he formulated in the following way [35]:

> *In my judgment, a police officer can owe a duty of care in directing other police officers to perform an armed interception. The content of the duty here would be to take reasonable care to ensure that such an interception took place in such a location and at such a time as to minimise, so far as reasonably practicable, the risk of unnecessary injury to the subject of the intervention, to the officers concerned and to others in the immediate vicinity. In this case, the duty would not arise before the point at which firearms officers were ordered to move through with a view to performing an interception* [Ruling on Verdicts and Inquisition (24th November 2008)].

14. This ruling predated the Supreme Court's decision in *Robinson v West Yorkshire Police* [2018] A.C. 736 but is consistent with that decision. In particular, Sir Michael did not restrict the duty of care on the basis of public policy [46], which was key to the re-focusing of the law in *Robinson*.

15. The MPS draws the chairman's attention to what Sir Michael said at paragraph [48] of his judgment in *de Menezes,* about the difficult lines that have to be drawn in recognising where the police do and do not owe a duty. The ambit of the TFC's duty would have to be established and carefully defined if a finding of gross negligence manslaughter were to be considered.

16. The positive duty on the state imposed under Article 2 of the ECHR is self-evidently wider than the duty of care to be imposed by the law of negligence. The two cannot be conflated as the family seek to do at paragraph [364] of their closing statement.

ii. BREACH OF THE DUTY OF CARE

17. It is necessary to establish with precision what is said to amount to the breach or the breaches of the duty of care. If a broad-brush approach is taken, then there is a significant risk that the court will take matters into account which were (for instance) not causative or otherwise do not fall within the ambit of the offence.

18. A broad-brush approach also risks flouting the obvious point that gross negligence manslaughter is an individual offence. Where, as here, only one person is said to be culpable, it is not possible to aggregate the conduct of others and ascribe it to that person.

19. The court must also carefully determine whether the relevant criticisms of the TFC are capable of amounting to a breach of the duty of care, as opposed to general criticism. In *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 p.586-7, the court held that:

"Negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent... [a doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, ***a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."***

20. This means that in order to prove that a TFC has breached their duty of care it must be shown that there are no responsible trained TFCs who would regard the relevant conduct as acceptable. That is the view taken by the relevant prosecuting body in England and Wales (see the CPS guidance for Crown Prosecutors, Gross Negligence Manslaughter, subsection on *Breach of Duty*).[1]

21. Expert evidence would be critical in establishing whether there has been a breach of the duty, see *R v Sellu* [2017] 4 W.L.R. 64 and the *Compendium* at [10].

22. The alleged breaches (whether omissions or positive acts) must be clearly identified, and the court will need explicit guidance on which aspect of the defendant's conduct it is to focus on in deciding whether there was a breach, see the *Compendium* at [18].

iii. SERIOUS AND OBVIOUS RISK OF DEATH

23. It must also be proved that at the time of any established breach, there was a serious and obvious risk of death.

24. An obvious risk *is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent*

[1] https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter, updated 14 March 2019.

on further investigation (*Broughton*, above). These are objective factors that are not reliant upon the defendant's knowledge.

iv. REASONABLY FORESEEABLE AT THE TIME OF THE BREACH OF THE DUTY THAT THE BREACH GAVE RISE TO A SERIOUS AND OBVIOUS RISK OF DEATH

25. The fourth element is to be contrasted from the third. It requires that it was reasonably foreseeable that the breach of the duty gave rise to a serious and obvious risk of death.

26. The same definition as to what amounts to obvious risk of death set out above applies. Importantly this question is judged subjectively. In *R v Rose* [2018] Q.B. 328 (and as cited at Compendium at [12]), Leveson LJ confirmed that the question of whether there was a serious and obvious risk of death must be assessed with respect to the defendant's knowledge at the time of the breach of duty:

> *In assessing either the foreseeability of the risk of death or the grossness of the conduct in question, the jury are not entitled to take into account information which would, could or should have been available to the defendant had he not breached the duty in question.*

27. In other words, if a serious and obvious risk of death was not foreseeable because the defendant was unaware of information which should have been available to him, then the offence will not be made out, even if the defendant was not aware of this information as a result of his breach of the duty or duties in question.

v. CAUSATION

28. It must be proved that the breach actually made a more than minimal causal contribution to death. Increasing the risk of death is not enough (*De Menezes* [32]).

29. This reflects what is set out in *Archbold* [2021] at 19-123:

In Broughton (above), a case involving a failure to seek medical treatment following the ingestion of controlled drugs, the Court rejected the prosecution's submission that in cases of gross negligence manslaughter the limit of the obligation on the prosecution is to prove that the failing in question deprived the victim of a significant or substantial chance of survival that was otherwise available at the time of the defendant's negligence, and held, approving and following Morby (19-12 above), that the prosecution must prove to the criminal standard that the gross negligence was at least a substantial contributory cause of death; in other words it must be proved that the deceased would have lived in the sense that life would have been significantly prolonged.

30. This question is easier to determine in medical cases where there will be expert evidence which can assist as to whether a patient would have survived were it not for the breach of duty. The question is more difficult when considering the position of a police officer planning an operation in which a suspect was fatally shot, but nonetheless the court must be able to make a finding, which will not be possible if based upon fine margins and/or speculation.

vi. GROSSNESS

31. A gross breach sufficient to engage the criminal law is far higher than a simple breach of duty as defined in *Bolam v Friern Hospital Management Committee* (above).

32. The breach must be "truly exceptionally bad". Plainly any breach of a duty of care which causes death will be viewed in hindsight as bad and a tragic loss of life. However, for it to be gross, "*it must have been so bad, so obviously wrong, that, having regard to the risk of death involved in it, it can properly be condemned as criminal" Sellu,* [151].

33. Different terms and tests have been used to describe the level that will amount to gross negligence. They uniformly point to a test of exceptionality. In *R. v Misra and Srivastava* [2005] 1 Cr. App. R. 21 at [25-6] the Court of Appeal cited, with approval, the following passages from the trial judges summing up:

"Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment are nowhere near enough for a crime as serious as manslaughter to be committed."

34. In *Sellu* [152], the Court of Appeal quashed the conviction as:

"the judge failed to direct the jury sufficiently as to the line that separates serious or very serious mistakes or lapses from conduct which was truly exceptionally bad and was such a departure from that standard [of a reasonably competent doctor] that it consequently amounted to being criminal."

35. The court stressed the importance of explaining to the jury the seriousness of the departure from ordinary standards required by the concept of gross negligence and that expert evidence will be important in this regard. Whilst all such questions are for the court and not expert witnesses, it is not sufficient simply to leave to the court the question of whether the departure was gross or severe. The court further outlined at [152] that what was needed was:

that the jury are assisted sufficiently to understand how to approach their task of identifying the line that separates even serious or very serious mistakes or lapses, from conduct which was truly exceptionally bad and was such a departure from that standard that it consequently amounted to being criminal.

IV. SUBMISSIONS (GROSS NEGLIGENCE MANSLAUGHTER)

36. Applying the above to the facts of the tragic death of Jermaine Baker and the proposition advanced in the family's closing submission, the following is apparent:

i. Matters which relate to the investigation and/or are in the sphere of the SIO, SFC (or other individuals) are not relevant as they would be attributable to an alleged default of another.

ii. Any alleged default that relates to the management of the CMP cannot be attributed to the TFC. The family submit such alleged breaches are attributable to the SIO and/or TSU.

iii. The family's submission that the TFC missed important information from the probe which could and should have altered his actions is not relevant in relation to gross negligence manslaughter.

iv. There is no support, beyond assertion in the family's submission, for the proposition that any alleged failure of the TFC could come close to the exceptional threshold of grossness.

v. When considering the submission at (iv) above, it is relevant that the TFC was not acting in isolation. He was being supervised by the SFC who was at times being shadowed. He was accompanied by a tactical adviser. He was working with a ground TFC who was herself being shadowed. There was an experienced OFC appointed who was in a position to challenge the TFC if he was concerned by the tactical plan or its execution at any time.

vi. None of these individuals raised any concern during the operation. All who gave evidence were supportive of the TFC. Whilst the family dismiss this as "*firearms orthodoxy*", there is independent support for this, for instance from ACC Hartley. Even if the chairman disagreed with each and every one of the above individuals, the broad support for the TFC is inconsistent with a breach of duty of care and renders an allegation of a gross breach unsustainable.

vii. There is no evidence that any of the identified breaches caused death.

37. Where multiple breaches are said to amount to gross negligence, the chairman must identify the alleged breaches with care to see if they support the strict test under the common law, see the *Compendium* [18]. The matters which the family have identified as being of "particular significance" are set out at paragraph [364] of their closing statement. The MPS has analysed the areas identified in this paragraph, including the main supporting submissions set out earlier in the family's

document. Whilst the family suggests that these are only the matters of "particular significance", this paragraph is the only attempt that is made to itemise the relevant acts and omissions attributable to DCI Williams. It would not be possible to ask whether an offence is made out by reference to the totality of the family's 131-page submission. This lacks the necessary specificity. Without specificity, the exercise will inevitably stray into areas that are plainly non-causative, outside the duty of care, or involve the acts or omissions of others.

(a) <u>Failures in the management and handling of the intelligence</u>

38. This is not the same as briefing the intelligence which is dealt with at [364 (b)] and addressed below. This appears to be further defined at [360 (d)] as:

> *Mr Williams egregiously failed to ensure the proper management of intelligence, the lifeblood of the entire operation. He failed to comply with the MOPI and NIM guidance (and associated APP guidance) in relation to the collation recording, evaluation (including grading), dissemination and review of police information including specifically intelligence.* ***This resulted in the misrepresentation of the intelligence position to WGCC and more significantly in relation to Jermaine's life, to the CTSFOs as the briefings they received on the morning of 11 December. They were wrongly caused or permitted the message to be conveyed to the CTSFOs that the intelligence was high grade and reliable that those in the mission vehicle would be carrying real weapons.***

39. It is implicit in the above that the alleged causative element is confined to the apparent briefing to the CTSFOs *that the intelligence was high grade and reliable that those in the mission vehicle would be carrying real weapons.*

40. The TFC was entirely right to say that it was difficult for him to answer why he had not graded certain intelligence in OPEN session at **7/161/15-25**, a point raised by the family at [95]. The chairman has heard the explanation for this in CLOSED and the point is dealt with at [14] of the NCA CLOSED submissions. That he did not grade certain intelligence is not a breach of any kind.

41. The intelligence received by the MPS was as the TFC stated high grade and reliable for reasons examined in both OPEN and CLOSED.

42. The briefing document sent to Wood Green Crown Court did not say that those in the escape plot definitely would have real firearms, it said that the intelligence *suggested* that they would. This was accurate. The note that was made in S105's log records that, in the 3AM briefing, the CTSFOs were told it was *believed [they] may be in possession of firearm,* which accords with DCI Williams's understanding of the position. S105 confirmed that he made this note whilst present at the briefing "*as he went along*" **10/42/17 – 10/43/9**. He was the only person present to take a note.

43. It is also important to note that at the main 5AM briefing the CTSFOs were correctly (in the view of all witnesses including the experts) told to *treat these people as armed until we know otherwise* [IPC0000238_007], but not given any information to suggest one way or another that the subjects definitely had access to firearms.

44. Even if the chairman were to conclude that there were failures in how the TFC managed and handled relevant intelligence, there has been no attempt to explain how it was reasonably foreseeable that such a failure would give rise to an obvious risk of death, far less that it caused death.

45. If this was a breach, it is also not of a kind that could be characterised as exceptionally bad in line with the law summarised above.

46. More generalised complaints about an alleged failure to record and grade intelligence, to break intelligence out by use of a CRIMINT and or to agree a form of words are on any view not causative (nor are they suggested to be). They do not amount to failings for reasons that have been addressed in CLOSED due to the nature of the intelligence in question.

b. ***Failure to ensure accurate and up to date briefing to CTSFOs of any changes in the intelligence picture relevant to the threat assessment which resulted in CTSFOs both at the briefings before their deployment and at 7.30 a.m on 11 December being led to believe that the threat they faced was far graver than the intelligence disclosed and in particular that the occupants of the mission vehicle were definitely armed***

47. The content of the pre-deployment briefings and the 0730 "firearms enabled transmission" will be addressed separately.

48. The content of the 3AM and 5AM briefings are addressed above. It is noted that the family adopt a starting position at [179] that they:

> *address the issue on a hypothetical basis which assumes that the intelligence which the MPS was in possession of or could have been in possession of - had those responsible taken steps reasonably open to them -* ***was to the effect that the conspirators had repeatedly tried but failed to secure a firearm, or otherwise contradicted the briefing actually given.***

49. The above hypothetical basis which refers to "pre-briefing intelligence" is demonstrably wrong by reference to the revised gist, and in particular by reference to the conspirators trying but failing to secure a firearm.. The chairman heard detailed evidence in CLOSED on this point. This was not the effect of the intelligence.

50. The MPS has made full submissions in relation to the decision not to brief the 06:58 intelligence, these are at [148] – [158] of its closing statement and are not repeated here. For the reasons already provided, the MPS submits that the TFC was not at fault in relation to this decision.

51. Even if the chairman were to conclude that the TFC should have disseminated this intelligence the evidence does not support a conclusion that this is a decision no reasonable TFC would have made. He was supported in this decision by S105 (now a TFC) see **10/68/18 – 10/69/17** and S48 (himself a specialist TFC) **9/145/11- 14**.

52. As set out at paragraphs [148 - 158] of the MPS closing statement, the TFC did **not** decide not to brief this intelligence on principle. He decided to wait and see if it was confirmed or not by what he heard on the probe. Based upon what he was told from the probe, the TFC was concerned that there was a firearm in the car. The experts agree that this a valid interpretation. This informed his decision not to brief the 06:58 intelligence in the event. Whether the chairman concludes he was right or wrong, it was not reasonably foreseeable that this decision would create a serious and obvious risk of death.

53. Furthermore, the decision was not causative. The evidence of the CTSFOs including W80 was one-way that even if they had been told this intelligence, it would not have made a difference to them, as they would continue to treat a firearm as real unless it was proved to be otherwise (paragraph [155] of the MPS closing).

54. Finally, even if the chairman were satisfied that the decision not to brief the 06:58 intelligence was a breach of his duty of care (which of course could not be expressly recorded as a finding), for the reasons set out in the main MPS submission it could not amount to a truly exceptional breach and was not regarded as such by the IOPC which focused on that issue. The TFC had to make a difficult decision as to whether to provide information to the firearms team when he was in possession of changing and apparently contradictory information. Whilst APP provides general guidance on the content of briefings, neither APP nor the NPFTC provides guidance on what to do with the difficult question of briefing intelligence about imitation firearms. The experts agreed that this was an area that was worthy of more detailed consideration (by the College of Policing) **22/41/8-9**.

55. The second aspect of the pre-deployment briefings relates to the 07:30 "firearms enabled transmission". The MPS does not repeat the submissions set out at [159] to [163] of its closing as to why this was a proper course for the TFC to take.

56. As with the 06:58 intelligence, however, even if the chairman were of a different view, this is not conduct that meets the threshold for a breach of duty. Others would have done the same. ACC Hartley (the IOPC expert) was of the view that:

the circulation of firearms enabled at 0730 does not bring any new information to the officers. They were already aware they were on authority ot face potentially armed offenders and this brings no further detail of weaponry location or accessibility. This acts as a reminder of what was known already. It is a legitimate and accurate circulation.

57. The highest that the inquiry experts put this is as *an unfortunate use of terminology* **22/159/6** and *a fairly significant issue* **22/159/13**.

58. It cannot seriously be suggested that if (as is not accepted) the transmission amounts to a breach of duty it was reasonably foreseeable that this presented an obvious risk of death. It simply did not. The TFC and others in C3000 who were involved in the transmission understood the term to relate to either an imitation or a real firearm. Whilst the CTSFOs understood it to relate to the presence of a real gun the overwhelming balance of the evidence is that it did not increase their threat assessment. This is a point which the experts raised in their report and confirmed in their oral evidence **23/46/14-22**.

59. The highest that the case can be put in relation to causation under head [346 (b)] is the answer W80 gave **21/183/17 – 21/184/**21, that if he had been told the imitation firearms intelligence **and** that firearms enabled could mean an imitation, his risk assessment would still have been high (but contrasted with very high). The TFC could not possibly have known this in advance. It could not safely be concluded to any standard that if W80's assessment was high rather than very high he would not have shot Jermaine Baker (meaning that causation cannot be established); neither would it be reasonably foreseeable that not to brief this information would pose an **obvious** risk of death.

60. As with the 06:58 point, the alleged breach of duty comes nowhere near the exceptional standard required for gross negligence, particularly when one considers that the TFC was between 06:58 and 09:00 making decisions in real-time with intelligence being fed to him from the probe.

c. TIPPING POINTS

61. To the extent that the family submit that setting evidential tipping points was or should have been the responsibility of DI Murray, it cannot be a matter that amounts to a breach of duty by the TFC, see for instance paragraph [204] of the family's closing statement in which it is submitted in relation to setting tipping points, that it would have been *wholly inappropriate for* DCI Williams *to undertake that role. This was properly the role of the SIO.* If that is correct then this alleged breach of duty fails as it is an attempt to attribute alleged failures from another individual to the subject of the alleged offence.

62. There is no content in APP or NPFTC as to who must record tipping points or in what form. Indeed these are not referenced in either document. What is clear is that the TFC must (i) be independent from the investigation and (ii) able to control the firearms operation so as to ensure that a desire to obtain evidence does not undermine the working strategy. The strategy must minimise risk to first the public and then the other subjects including the suspects. The TFC stated that this was his intention in terms where he recorded within his log [MPS0003577_003]:

> *I have considered tipping points and it is difficult to be precise prior to the operation with three different surveillance deployments, ultimately for me it is all about control if at any stage I take the decision that I have insufficient control to maximise the safety of all parties I will revert to overt protection even if this is to the detriment of evidential opportunities.*

63. The TFC stated in evidence that he definitely had tipping points in mind. If there was evidence that firearms could be recovered, he would have arrested at the earliest opportunity when it was safe to do so, see **7/146/13-20** and **17/148/19-24**. Alternatively, he would have arrested once evidential sufficiency had been obtained in relation to a substantive criminal conspiracy **7/147/3-8**. There was always a geographical tipping point which acted as a backstop and ensured that arrests would not be made at a dangerous moment **7/147/8 – 7/148/148**.

64. At paragraph [207] of their closing statement, the family reference an exchange between DCI Williams and CTI where various pieces of information were put to him and he was asked whether this would meet the tipping point. The family dismiss his answers as *ex post facto rationalisation of his indefensible failure to ensure that agreed tipping points were established with the SIO*. No reference is given for the relevant exchange, but it occurred between **13/162/3 – 13/16/171/25**. All of these matters, however, were **not** known to the TFC at the time of the operation. The TFC cannot have breached a duty of care based upon information that was not passed to him. To the extent that this is said to be a failure of the CMP/TSU the family accept that these matters do not attach to DCI Williams.

65. This accords with how the family characterises the breach relating to evidential tipping points at [238] (emphasis added):

> *Had the probe been handled competently then there can be no doubt that those listening would have confidently established by 7.30 am that they had enough evidence of the conspiracy to make an arrest with sufficient evidence to support a prosecution.* ***But for the incompetence with respect to the instalment, operation of the probe and management of the CMP, by 7.30 am Mr Williams would have been presented with sufficient evidence to support a prosecution for possession of an imitation firearm with intent to commit an indictable offence contrary to s. 18 Firearms Act 1968.***

66. This is repeated at [245]:

> *Had the CMP itself been staffed by trained officers and supervised and managed by a competent trained CMP manager,* ***the family contend that Mr Williams would have been provided with enough information to establish a clear tipping point by 7:30*** *in respect of a s18 offence.*

67. The family's complaint therefore is not that State Amber was not called earlier **because the TFC had failed to set tipping points** but that this did not occur because he was not informed of information due to ***the incompetence with respect to the instalment, operation of the probe and management of the CMP***. The

family state that "blame" for the CMP lies with Mr Murray and the TSU see in particular [360 g – h]. This of course is not accepted. It is apparent however that if (as is denied) there was a breach of duty it was not by the TFC but by those responsible for the *instalment, operation of the probe and management of the CMP*. This is obviously fatal to gross negligence manslaughter under this alleged breach.

68. There appears to be an inconsistent suggestion at [246] that the TFC should in any event have determined that state Amber had been reached by 0730. The family gives no proper basis to reject DCI Williams evidence that he did not consider he had sufficient evidence until the partial VRM was repeated and there is absolutely no proper basis to suggest that a decision not to do so was unreasonable.

69. Whilst the above disposes of this ground in any event the matters raised were not causative. There is a suggestion at [263] that had the TFC concluded that he had evidential sufficiency, he could have turned his sole focus to planning a safe interception. But even on the family's case he did not have the requisite evidence. It is asserted that from 0800, the TFC should have known that the Audi would wait on Bracknell Close until it moved to attack the prison van but this is wholly unexplained. The car could have moved on for any number of reasons not least of all as the occupants were unhappy with the location due to being seen by residents and builders [IPC0000281_0019].

70. The family suggest that various matters could have been worked on by the TFC from 0800 onwards including whether to perform a containment and callout. The MPS do not repeat the submissions that extraction was the appropriate tactical option. There is simply no evidence to support a submission that extraction should not have been the selected tactic in Bracknell Close.

d. <u>To use the available surveillance tools on the morning of 11 December to minimise the risks of an interception</u>

71. The family's submission is that the surveillance officers' interpretation that the Audi was engaging in anti-surveillance was wrong. This is wholly based upon the following evidence from DC Reddy who was relaying information from the probe

to the TFC but also had access to a police radio. Given the weight the family place on this evidence which it is suggested should have caused the TFC to countermand all of the evidence from the specialist surveillance officers at the scene and the surveillance commander, it is set out in full below **12/80/15 – 12/81/25**:

> MS BLACKWELL: Thank you, sir. Mr Reddy, I have a few questions from other core participants in relation to some aspects of your evidence which I have been asked to clarify. In relation to the first witness statement that you gave on 11 December, I am looking at page 2, you described your role in the Covert Monitoring Post as including this: "*Throughout the time I was also listening to the main radio channel and noted the concerns of the surveillance team that the vehicle appeared to be conducting anti-surveillance manoeuvres. I was informed by the listening officers that the occupants of the vehicle did not appear concerned and were joking about the fact that they were constantly getting lost. I relayed this to the SIO and the surveillance support within the operations room.*" Right, so does that suggest that, as well as speaking to Mr *Hawthorn and receiving from him the information which he was relaying, there was also access to another radio channel in that room?*
>
> *A. Yes, we had -- we were monitoring one radio channel and that would have been the surveillance team of the vehicle, the Audi.*
>
> *Q. Right. Thank you. How were you able to listen to that additional radio channel?*
>
> *A. It was more the -- I use the word background, it was just as I said earlier when I was asked the question, it was to allay any concerns as did happen, that, if we were aware the surveillance team were concerned about something, we could monitor what was being said in the vehicle and give them a bit of -- as I say, the intention is to give them a bit of confidence that there is no suspicion and they can continue to surveil the vehicle.*

72. To suggest that this observation from an officer in the CMP should have caused the TFC to have ignored the evidence to opposite effect from the surveillance team

is it is respectfully submitted wrong. It should be noted at the outset that the surveillance support was aware of what DC Reddy had heard on the probe. The surveillance manager would therefore have been able to pass this onto his team if he thought it appropriate. This would have been a matter for him not the TFC. Whilst DC Reddy's observation was relevant, it was contradicted by overwhelming evidence from the highly trained specialist surveillance officers that the Audi **was** engaged in anti-surveillance this is summarised in the MPS submission at [181] and includes evidence from Chris Davies who was of the view that the Audi *definitely* was involved in anti-surveillance notwithstanding the fact that he had been provided with the update from DC Reddy see **14/111/1 – 14/113/18**.

73. If there were any doubt on this point, FE10 who was present on the ground watching the Audi gave the clearest possible evidence and dealt with the issue raised by DC Reddy in terms:

> *"Q. Yes, if you had been told that in fact rather than being twitchy, the occupants of the vehicle were joking about being lost in the car, would that have influenced your decision as to how close you would have asked your men to move in?*
>
> *A. Not really, because in my experience, sometimes when you have got say three people in the car that are of a sort of gang nature, as it were, or involved in that type of criminal behaviour, sometimes they -- it is almost like a bit of banter, they don't want to lose face with somebody else, so you cannot always take it as gospel what they are saying, they might be saying we are lost, it might appear they are joking, whereas one of them might be thinking I think the police might be with us but they don't want to say anything. So, you know, from my point of view I would always err on the side of caution unless we knew 100 per cent that they were happy,* ***but all I tell you is their behaviour on that day, for me as an experienced surveillance officer, it was anti-surveillance, they wasn't lost, they wasn't mucking about, they was clearly 100 per cent conducting anti-surveillance. Hence me 1 saying, "Team, back off, just give them some space, we don't want to compromise the operation" "***

74. Additionally the content of the probe contradicts what the family submit about the occupants "joking" and therefore not being surveillance aware. It must not be forgotten that they were engaged in very serious criminality on 11.12.15. Only the most hardened criminal would approach this in a light hearted spirit. Plainly they did not want to be caught hence why there were "eyes about" as FE11 put it. This is manifestly confirmed by their conversation in the car about "Feds" residents and builders watching them. It was correctly perceived by the officers on the ground.

75. The TFC would have been acting unreasonably if he had ignored the views of the highly trained surveillance officers. To conclude that the occupants were surveillance aware was without doubt a reasonable conclusion for him to draw. It could not be said that this was a breach of duty. It could not be said that to accept the surveillance teams proposal to back off resulted in a serious and obvious risk that Mr Baker would die much less that this was reasonably foreseeable. It was not incompetent or grossly so.

76. Even if the other elements were made out which they manifestly are not the surveillance team backing off between 0806 and 0900 did not cause Jermaine Baker's death. The family submit at [272] that the TFC could and should have told the surveillance team that the occupants *appeared to be asleep having smoked some cannabis*. It is not known how the TFC should have been aware that all the occupants were asleep (they were not) nor that they had smoked cannabis (there is no evidence to support this). The family assert that there *would have been nothing unusual about the presence of another person on the street* but the occupants were already suspicious of the builders and residents and this was not the view of the specialist surveillance officers.

77. At [273] the family faintly suggest that had *this happened* the preferred tactic could have been containment and callout. As has been comprehensively established the evidence is one way that this would not have been appropriate.

78. The family further suggest at [274] that a "*proper reconnoitre*" would have revealed (with the probe evidence) that (a) there were only 3 occupants in the car, (b) it was parked close to another vehicle which would compromise the CTSFOs

ability to perform an extraction and (c) it was highly unlikely that there would be a firearm in the vehicle. That an imitation firearm with a cannister was likely to be used. This obviously conflates matters relating to the CMP with what is being examined here which is the surveillance deployment. As set out above the CMP issues does not assist in building a case for gross negligence manslaughter.

79. In any event that these matters were not known did not cause Jermaine Baker's death. The CTSFOs could deal with 3 or 4 occupants. The position of the BMW was something that CTSFOs train for. They train to execute the tactic with a brick wall on one side. S111 was aware of the location of the BMW and not surprised by it or its location, see MPS submissions at [185].

80. The use of the surveillance team could not possibly amount to gross negligence.

81. The MPS submits that taken alone or cumulatively these matters are wholly incapable of amounting to gross negligence manslaughter.

82. The family's suggestion at [360] (i) and (j) and [365] that no attempts were made to mitigate the risk to the subjects are flatly contradicted by the evidence of the experts who stated at **22/115/8**:

> ***the evidence appears to be that they were putting the right mitigation factors in place*** *but it was always going to be a high risk operation, particularly if for some reason they were blindsided a term that they have used in their statements in respect of the SERCO vehicle*

83. For the reasons set out in this document and within the MPS submission the overall performance of the TFC (which could never be a proper basis for a clearly identified breach of duty) would also fall way short of the elements required to prove gross negligence manslaughter.

V. SUBMISSIONS (MURDER / SELF DEFENCE)

84. The MPS agrees that the applicable legal principles in respect of the issue of unlawful killing are as set out in CTI's note on the law. It is, however, necessary to make further comment about this in light of the family's submissions on unlawful killing, and the propositions set out at paragraphs [18] to [28] of their closing statement.

85. In inviting the chairman to reach a conclusion on objective reasonableness, the family have commented that "*the Chairs of similar public inquiries have taken different approaches*", relying in particular on the course that was taken in the public inquiry into the death of Azelle Rodney. That inquiry, however, pre-dated the decision of the Court of Appeal in *R (Duggan) v Assistant Chief Coroner for North London* [2017] 1 WLR 2199, which determined that when considering the short form conclusion of unlawful killing it is the criminal test that is applied.

86. The Court of Appeal concluded at paragraphs [93]-[94] of its judgment in *Duggan*:

> *93. We were not shown any domestic case which requires an inquiry as to breach of the civil law at an inquest. The judgment of the Divisional Court gave a succinct and lucid historical account of the former verdicts at an inquest of justifiable or excusable homicide and the modern conclusions of lawful and unlawful killing. As that account shows, it has never been the function of an inquest to concern itself with civil liability for a death, and the conclusion of lawful killing has always been understood to have been linked to crime and amounted to a statement that the jury believed that the deceased was probably not the victim of a homicide.*
>
> *94. So far as concerns article 2, there is no decision of the ECHR which expressly states that the procedural requirements of article 2 impose an obligation on the state to investigate a breach of the civil law. Indeed, such an interpretation of article 2 would be contrary to the policy and purpose underlying article 2 and was implicitly rejected in the Da Silva case 63 EHRR 12 .*

87. The Grand Chamber of the ECtHr held in *Armani Da Silva v United Kingdom* (App. No. 5878/08) (2016) at [244] that the test to be applied as to whether the use of lethal force by the state is justified is that set out in *McCann* and, having considered the criminal test for self-defence, concluded at [252] that "*it cannot be said that the definition of self-defence in England and Wales falls short of the standard required by Article 2 of the Convention*". In other words, Article 2 does not require a finding as to whether the use of fatal force would have amounted to a civil wrong.

88. Since the decisions in *Da Silva* and *Duggan*, this issue has been expressly considered in the context of a public inquiry by the chairman of the Inquiry into the Death of Anthony Grainger. HHJ Teague reached the following conclusion at paragraph 6.10 of his report:

> *Having regard to the Terms of Reference of this Inquiry and the circumstances in which I have come to conduct it, as well as its subject matter and inquisitorial nature, I take the firm view that I should apply the criminal, and not the civil, law when assessing the legality of the use of lethal force by Q9.*

89. HHJ Teague gave as his reasons for this conclusion the fact that he was holding an inquiry only because he had determined that an Article 2 compliant inquest could not be held and noted the similarities between the public inquiry he was conducting and an inquest. Unsurprisingly, he referred to the decision in *R (Duggan) v Assistant Chief Coroner for North London [*2017] 1 WLR 2199 (at [paragraph 6.13] of his report).

90. Respectfully, the MPS submit that there is no reason to depart from that course and that it would be wrong to do so.

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3 September 2021