Narrative conclusions of the Keyham Jury – Box 3 Pt II and box 4

Box 3: How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances e deceased came by his or her death:

[*The jury described the events of 12 August 2021 as it related to each deceased and gave the medical cause of death, and continued:*]

The perpetrator came to be and remain in lawful possession of a shotgun at the material time due to the following circumstances:

The initial shotgun licence application:

In 2017, given the absence of medical information, the known history of assaults and the intelligence held by Devon & Cornwall Police suggesting involvement in other violent episodes, it was a serious failure to protect the public and the peace to grant a licence to the perpetrator.

There was a serious failure within the Firearms and Explosives Licensing Unit (FELU) to heed and apply the 2016 Home Office guidance, that high risk decisions on grant of a licence should be made by the Firearms Licensing Manager (FLM).

Despite the 2016 Home Office guidance in force at that time, inadequate steps were taken to obtain specific medical evidence regarding the extent to which the perpetrator's declared autism and Asperger's might impact upon his suitability to hold a shotgun licence.

This was further compounded by the confusion caused by the move from the use of a post to pre-grant letter, without the update to the Home Office guidance which previously stated would be provided.

It was not a safe system to assume that in the absence of a substantive response to the standard pre-grant letter from the GP, there were no relevant medical conditions that could affect the perpetrator's suitability to hold a shotgun licence.

The mechanism agreed by the FLM and Local Medical Committee to obtain specific factual information about a self-declared medical condition was not communicated to or followed by the Firearms Enquiry Officer (FEO) or the Firearms Licencing Supervisor (FLS).

The referee's tasks and responsibilities were not made clear and insufficient inquiries were made of the referee given the known history of assaults at school.

Reflecting the culture within the FELU at the time, an insufficient degree of professional curiosity was demonstrated by the FEO and FLS.

The review of the licence:

The decision to return the shotgun and licence to the perpetrator in July 2021 was fundamentally flawed and as a result failed to protect the public and the peace.

The officer investigating the skate park assaults in September 2020 should have noted that the perpetrator was a firearms certificate holder and taken immediate steps to alert the FELU to the incident.

It was unreasonable to categorise the level of the assault upon the boy in the skate park as battery. There were clear aggravating factors to suggest this should have been charged at a higher level and there was inadequate investigation of whether the assault on the boy in the skate park had led to his unconsciousness.

The use of the Pathfinder scheme in this instance was wholly inadequate in reducing the perpetrator's future offending.

On reviewing the perpetrator's suitability to retain the shotgun certificate, the FEO ought to have shown a greater degree of professional curiosity in obtaining and evaluating further information. The case was not passed to the FLM for review which was against Home Office guidance.

General:

There was a serious failure at a national level by the government, Home Office and National College of Policing to implement the recommendation from Lord Cullen's Report in 1996 arising out of the fatal shootings in Dunblane, to provide training for FEOs and the subsequent recommendation in Her Majesty's Inspectorate of the Constabulary's Targeting the Risk Report in 2015 for an accredited training regime for FEOs. The most recent statutory guidance from the Home Office (2021) has failed to include any mention of FEO specific training.

The training and informal mentoring was insufficient to enable the FEOs to safely discharge their duties. Informal mentoring had inherent limitations, meaning incorrect processes were perpetuated and not formally recorded as an agreed training method to deliver learning outcomes.

There was a catastrophic failure in the management of the FELU, with a lack of managerial supervision, inadequate and ineffective leadership. This was compounded by a lack of senior management and executive leadership who failed to notice or address the issues.

There was a lack of scrutiny and professional curiosity at all levels. The ineffective auditing and governance of the FELU in place led to an inadequate system of dip sampling, qualitative assessment of staff's decision-making, and learning from the results of the same.

There was a seriously unsafe culture within the FELU of defaulting to granting licences and to returning licences after review.

There was a dangerous lack of understanding on the part of the Devon and Cornwall Police FELU staff regarding the use and application of the FELU risk matrix.

Incompatible IT systems both within Devon and Cornwall Police and outside agencies contributed to a failure to communicate effectively.

Budgetary limitations and staff shortages within Devon and Cornwall Police increased the probability of risk being incorrectly assessed which led to unsafe licences being issued. These limitations were not confined to Devon and Cornwall Police but also existed at a national level, for example the National College of Policing not assigning resources to run an accredited national FEO training course.

Box 4: Conclusion of the jury as to the death:

The deceased was unlawfully killed.

The death was caused by the fact that the perpetrator had a lawfully held shotgun; the following contributed to this position.

There were serious failures by Devon and Cornwall Police FELU in granting and, later, failing to revoke the perpetrator's shotgun certificate.

In licencing the perpetrator to have a shotgun there was a serious failure by Devon and Cornwall Police to protect the deceased.

There was a failure of Devon and Cornwall Police to have in place safe and robust systems. Foremost, the training of FELU staff, governance of the FELU, quality assurance of FELU staff's decision-making and ensuring decisions were made at the correct level.

There was a failure by Devon and Cornwall Police FELU staff to obtain sufficient medical information in respect of the perpetrator's application for a shotgun certificate and also on review.

There was a failure by Devon and Cornwall Police FELU staff to properly seek out and consider all the relevant evidence and information available before deciding whether to grant the perpetrator a shotgun certificate.

Following the perpetrator having assaulted two children in 2020, there was a failure by Devon and Cornwall Police to protect the public and the peace. Firstly, within the Local Investigation team regarding the downgraded charge and secondly, within the FELU to sufficiently investigate whether it was safe to return to the perpetrator his shotgun and certificate after initially seizing them.

Incorrect application of the risk matrix meant there was a serious failure by Devon and Cornwall Police to implement an adequate system to ensure that the decision whether or not to (i) grant or (ii) return a shotgun certificate following review, was made or approved by a manager of sufficient seniority.

A lack of national accredited Firearms licensing training has and continues to fail to equip police staff to protect the public safety.

There was a catastrophic failure in the management of the FELU, with a lack of managerial supervision, inadequate and ineffective leadership. This was compounded by a lack of senior management and executive leadership who failed to notice or address the issues.

20 February 2023