REPORT TO PREVENT FUTURE DEATHS: MADE UNDER REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

REPORT REGARDING TRAINING OF FIREARMS LICENCING DECISION MAKERS

	THIS REPORT IS BEING SENT TO: 1. Rt Hon. Suella Braverman MP, The Home Secretary 2. Rt Hon Chris Philp MP, Minister of State for Crime, Policing and Fire 3. NPCC lead for policing, CC Tedds 4. All Chief Constables in England and Wales 5. The College of Policing This document is but one of a number of prevention of future deaths reports that I am issuing following the inquests into the five deaths of those shot by Jake Davison in Keyham on 12 August 2021. I shall copy every addressee all other prevention of future death reports arising from these inquests for their information.
1	**CORONER** I am Ian Arrow, Senior Coroner for the coroner area of Plymouth, Torbay and South Devon.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 19 August 2021 I commenced an investigation into the deaths of Maxine Davison (age 51), Lee Martyn (age 43), Sophie Martyn (age 3), Stephen Washington (age 59) and Kate Shepherd (age 66). The investigation concluded at the end of the inquest held before a jury on 20 February 2023. The conclusion of the jury in respect of these five conjoined inquests was as follows: **Maxine Betty Davison** On the 12th August 2021 between 18:05-18:08, Maxine Betty Davison died as a result of shotgun wounds to the head and torso. This occurred at her address, 17 Biddick Drive following an argument with the perpetrator. **Lee Raymond John Martyn** On the 12th August 2021 between 18:08-18:10, Lee Raymond John Martyn died as a result of shotgun wounds to the head and torso. This occurred whilst walking with his daughter Sophie Iris Martyn in the street, Biddick Drive, Keyham, Plymouth. **Sophie Iris Martyn**

On the 12th August 2021 between 18:08-18:10, Sophie Iris Martyn died as a result of a shotgun wound to her head. This occurred whilst walking with her father Lee Raymond John Martyn in the street, Biddick Drive, Keyham, Plymouth.

Stephen John Godfrey Washington
On the 12th August 2021 between 18:10-18:12, Stephen John Godfrey Washington died as a result of a shotgun wound to his chest. This occurred whilst walking on Snakey path (Linear Park), a footpath behind Biddick Drive, Keyham, Plymouth whilst walking his dogs.

Kathryn Jane Shepherd (known as Kate).
On the 12th August 2021, Kathryn Jane Shepherd received a shotgun wound to her abdomen at 18:13 outside Blush Salon, Henderson Place, Plymouth and subsequently died later that day in Derriford Hospital, Plymouth.

In respect of each deceased the jury also found as follows

Under Section 3 of the Record of Inquest

'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.'

	The jury's conclusion in respect of each death under Section 4 of the Record of Inquest was as follows: '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.
4	**CIRCUMSTANCES OF THE DEATH** On 12 August 2021 Jake Davison, who was a licenced shotgun holder, took up his lawfully held pump action shotgun and loaded it with 12-gauge OOB 'buckshot' cartridge. He shot and killed his mother Maxine Davison at their home, and then entered the street where he shot six people who were strangers to him, four of whom suffered fatal injuries.
5	

CORONER'S CONCERNS

During the course of these inquests the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows.

Evidence I heard at these inquests revealed that numerous recommendations arising from previous inquiries and reviews regarding the training of police officers and police staff involved in firearms licensing decisions had not been put into effect. This is not a new concern but one that has previously been raised by at least two other coroners in earlier 'Prevention of Future Deaths' reports in other coronial jurisdictions. If any lessons had been learned in the aftermath of earlier tragedies, they have been forgotten and that learning had been lost.

I was told that all Chief Officers of police ought to be satisfied that they only delegate their authority to issue and revoke firearms and shotgun licences to appropriately trained and skilled personnel. However, over the past 27 years, there has been an abject failure to ensure that nationally accredited training of firearms licensing staff has been developed and its currency maintained. Specifically –

1. In 1996, following the murders at the primary school in Dunblane Lord Cullen's report (see here) recommended as follows:

> *'Enquiry officers should be given as much training and guidance for their work as is practicable.'*

The Government responded (see here) stating that

> "*The Government accepts this recommendation. Existing Home Office advice to police forces is that 'enquiry, administration and decision making processes' in each police force should all be controlled by a centralised firearms administration and that all inquiries should be made by nominated,* ***trained*** *staff.* ***The Guidance to the Police will be amended to emphasise the point****."*

In fact the guidance subsequently issued by the Home Office, in March 2002, entitled '*Firearms Law, Guidance to the Police'*, (here) made no recommendation regarding the training of staff. The 2002 guidance merely stated (at §1.5)

> *'Firearms legislation and the subject of firearms generally is complex and highly specialised. It is not practicable to provide comprehensive training for every police officer on the administration of the Firearms Acts. It is therefore essential that this guide is available to all police officers and civilians directly involved in the licensing process. Where difficulties arise, advice may be sought from the firearms department at the appropriate police force.'*

Indeed by March 2002 there was no accredited training for the role of firearms enquiry officers (FEOs) or firearms licensing managers (FLMs). The Home Office guidance to police did not contain any proposal or requirement that FEOs or FLMs should undergo training specific to their role. There was no requirement that FEOs or FLMs should undergo any training in assessing the suitability of applicants to be granted a licence.

2. Later in 2002 The Firearms Licensing Thematic Review entitled 'Safe Hands = Secure Arms' (here), conducted by Her Majesty's Inspector of Constabulary (HMIC) recommended as follows:

'Recommendation 2.

Her Majesty's Inspector of Constabulary recommends that ***force policy and procedure in respect of firearms licensing should mirror Lord Cullen's Recommendations*** *and ACPO Policy, Home Office Guidance and ACPO, 'Procedural Good Practice Guide'.*

Recommendation 3.

Her Majesty's Inspector of Constabulary recommends ***that forces ensure that staff conducting firearms enquiries are trained,*** *conversant with current ACPO /Home Office guidance and competent to fulfil their role.'*

However, despite those recommendations the absence of formal training courses for FELU staff in firearms licensing remained unaddressed.

3. In March 2013 the Senior Coroner for Durham issued a report under rule 43 Coroners Rules 1984 following the inquests into the deaths of Sam McGoldrick, Alison Turnbull, Tanya Turnbull and Michael Atherton:

The r.43 report, sent to the Chief Constable of Durham Police and the Home Secretary raised the following concern (among others):

*'**The inquest has revealed disturbing issues on the question of training. Notwithstanding the significant importance of the shotgun firearms licencing process there was no formal training courses available in 2006/2008 and even limited formal training available now.** Training was by virtue of learning on the job and by making enquiries oneself and familiarising oneself with the Home Office and ACPO guidance. Durham Constabulary did not have its own local policy relating to firearms/shotgun licencing. **Durham Constabulary was not alone in not having such a policy.** Not all individuals involved in the licencing process were aware of the existence of the Home Office and ACPO guidance documents, both published in 2002, let alone the detailed contents thereof…. This case has illustrated that the administration of firearms shotgun licencing system was… unclear on occasion and confusing. **And with the absence of training and clear guidance either locally or nationally, it created an environment in which it was easier for less than optimal standards to be achieved**.'*

The Home Secretary (The Rt Hon Theresa May MP) responded on 17 June 2013 stating that:

> '*Nationally a recognised training course is available for firearms enquiry officers and a system of mentoring uses the expertise of more experienced enquiry officers or managers.'*

If it was indeed the case that a national training course for course for firearms enquiry officers was available as the Home Secretary suggested in June 2013 this was no longer the case by 2014. I have been informed that in 2014 there was still no nationally accredited training available for the role of FEOs or FLMs. The College of Policing Authorised Professional Practice (APP) in 2014 (see here at section 2.6) merely stated that chief police officers should be '*seeking to develop appropriate accredited training for firearms licensing staff*.'

Furthermore the Home Office guidance published in 2014 still did not contain any proposal or requirement that FEOs or FLMs should undergo any (even non-accredited) training specific to their role. In particular, there was no requirement that FEOs or FLMs should undergo any training in assessing the suitability of applicants to be granted a licence.

4. In September 2015, HMIC conducted another 'inspection of the efficiency and effectiveness of firearms licensing in police forces in England and Wales' entitled '*Targeting the Risk'* (see here).

This report yet again raised concerns at the continuing absence of nationally accredited training for firearms licensing decision makers. The HMIC report stated that:

> *'While some training has been made available,* ***we are concerned at the continuing absence of nationally accredited training****. Its absence has meant that some staff involved in the licensing arrangements, in particular those charged with making firearms licensing decisions, have yet to receive sufficient training, commensurate with their role and responsibility.'*

HMIC noted in 2015 that proposals for accredited training were 'under consideration' by the national policing lead for firearms licensing and the College of Policing. However, the evidence I heard at the inquest was that this 'consideration' did not result in any accredited training being developed. **Even today, some eight years later, accredited training for those charged with making firearms licensing decisions does not exist.**

In 2015 HMIC recommended to the national policing lead for firearms licensing, in conjunction with the College of Policing that:

> *'Within 12 months, the national policing lead for firearms licensing, in conjunction with the College of Policing, should identify the skills required by those staff involved in the firearms licensing process. Thereafter they should introduce professional development arrangements to ensure a consistent national approach to firearms licensing. Consideration should also be given to the accreditation of these arrangements.'*

That 2015 HMIC report also stated that

> *'On too many occasions, the police are not following the Home Office guidance or the Authorised Professional Practice. And, the guidance and practice in many respects are inadequate, allowing room for interpretation and the creation of inconsistency in the way firearms licensing is undertaken within and between police forces….*
>
> ***We cannot make our position any clearer: it is now for others to accept the need for change. If they do, perhaps the life of the next victim of firearms misuse might be saved. What is highly likely is that, if change is not effected, there will be another tragedy.'***

The Home Office guidance on firearms licencing was subsequently updated in 2016. However, that guidance made no reference to the need for firearms licencing staff to undergo accredited training. The 2016 Home Office guidance did not contain any proposal or requirement that FEOs or FLMs should undergo any (even non-accredited) training specific to their role. There was no requirement that FEOs or FLMs should undergo any training in assessing the suitability of applicants to be granted a licence.

Evidence presented at the inquests was that the College of Policing's Coordination and Delivery Group had declined requests made to it to develop a national training package in Feb 2016 and January 2019.

5. In 2019 Mr Richard Travers Senior Coroner for Surrey issued a report to prevent future deaths following the killings of Christine and Lucy Lee (see here).

That report, which was sent to Chief Constable of Surrey Police, the NPCC lead for firearms and the Home Office, raised the following concern:

> *'It was apparent from the evidence that, at the time of the deaths, there was* ***no national training course for staff working in police firearms licensing departments as Firearms Enquiry Officers*** *("FEOs"). I was told that work is now being undertaken by the College of Policing to produce an accreditation process for FEOs, but that this work is not yet complete.*
>
> *Currently, what is known as "the South Yorkshire Training Course" is available. This is a five day, residential course which appears to be comprehensive. I was told that all Surrey Police's current FEOs have completed the South Yorkshire Training Course, but that it is not mandatory for them to do so.*
>
> ***I am concerned that, pending the introduction of a full accreditation scheme, the absence of a mandatory requirement for all new FEOs (whether in Surrey or elsewhere) to undertake comprehensive training for the role****, in the form of the South Yorkshire Training Course or equivalent,* ***will result in the risk of insufficient training, incorrect decision making concerning certification and, consequently, future deaths.'***

By 2021, when Jake Davison's gun was returned to him, there was still no accredited training for the role of FEOs or FLMs, nor was there any mandatory requirement for FEOs or FLMs to undergo even non-accredited training specific to their role. In particular, there was no requirement that FEOs or FLMs to undergo any training in assessing the suitability of applicants to be granted a licence.

It is against this background of 27 years of wholesale failure to devise and maintain adequate training provision for firearms licensing staff nationally that the jury in the Keyham inquests returned their findings above, including that:

> *'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 available at Devon & Cornwall police was insufficient to enable the FEOs to safely discharge their duties, meaning incorrect processes were perpetuated and not formally recorded as an agreed training method to deliver learning outcomes.'*

The evidence I heard suggested the absence of training was not merely a local problem for Devon & Cornwall Police. I have been assured that work towards an accredited training package is now ongoing and I was also informed that that *some* police forces, do currently have in-house training programmes that firearms licensing staff from other forces may attend. However I have been informed that the availability of such local in-house training remains sporadic.

I am concerned that there is an urgent need to develop a national accredited training for FELU staff that covers how to apply the relevant Home Office Guidance on firearms licencing including, in particular, training in assessing the suitability of applicants to be granted a licence. The development of such accredited training is vitally important to achieve consistency and drive up standards.

I am concerned that there is currently no requirement or guidance that FELU staff should undergo mandatory training. I am also concerned that there is currently no requirement that Chief Officers of Police may only delegate decision making authority regarding issuing firearms licences to a person who has undergone adequate training.

Whilst I acknowledged that the current NPCC lead for firearms licencing is now working with the College of Policing and others to develop the required training, I am concerned to ensure that the momentum to effect change after the horrific tragedy in Keyham should not be lost, as it has been in respect of lessons and recommendations over the past 27 years.

I am therefore reporting the matters above to:

	The NPCC lead for firearms licencing and all other Chief Constables in England and Wales So that each Chief Constable is made aware of my concern that, that despite the many recommendations made over the past 27 years, there continues to be a lack of nationally accredited training for their FELU staff. I also report my concern that in the absence of such the training there is a risk that the Statutory Guidance is not being appropriately applied by FELU staff today, and so each Chief Constable may need to take steps to satisfy themselves that (i) adequate local training, of a satisfactory standard has been universally delivered to all their FELU staff and supervisors in applying the Home Office *Guidance on Firearms Licencing Law* (published in November 2022) and the revised *Statutory Guidance for Chief officers of Police* (published in February 2023) and (ii) they have only delegated decision making to persons who have undergone adequate training in firearms licencing and in applying that recent Guidance. **The College of Policing (CoP)** So that the College of Policing is made aware of my concern that (1) despite the repeated recommendations being made over the past 27 years, and the earlier requests made specifically to the College of Policing asking for such training to be developed, no accredited training as yet exists. (2) neither the current CoP APP guidance on firearms nor the proposed update (which I am aware is still under consultation) includes any requirement that FELU staff are trained in firearms licencing generally or trained in conducting suitability assessments in particular. **The Home Secretary and The Minister of State for Crime, Policing and Fire** So that they may be made aware of my concern that despite the repeated recommendations being made over the past 27 years, beginning with the Cullen report in 1996: (i) successive governments appear to have failed to ensure that any guidance is produced that makes having training in firearms licencing generally (and in conducting suitability assessments in particular) mandatory for all FELU staff; (ii) there appears to be no requirement that Chief Officers of Police should only delegate authority to issue and revoke licences to officers and staff who have completed adequate (and preferably nationally accredited) training. I am concerned that the lack of accredited training combined with the absence of a mandatory requirement for all those making firearms licensing decisions to undertake adequate training for their role increases the risk of incorrect decision making and, consequently, increases the risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 May 2023. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the Interested Persons listed on the appended document, and to the Local Safeguarding Board/Domestic Homicide Review authors. I have also sent it to those also named on the appended document who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**8 March 2023**  **Signed by Senior Coroner Ian Arrow**