Record of Inquest

Following an Investigation commenced on the 25 June 2020;
And an Inquest opened on the 29 July 2020;
And an Inquest hearing at the Central Criminal Court, London held from 15 January 2024 to 23 February 2024 on the 26 April 2024, heard before Sir Adrian Fulford PC KC, Nominated Judge Coroner.

The following is the record of the inquest (including the statutory determination and where required, findings)

1 Name of Deceased (if known)
David WAILS

2 Medical cause of death:

I a **Stab wound to the left subclavian artery and left common carotid artery**
I b
I c

II

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

On 20 June 2020, David Wails was with a group of friends in Forbury Gardens, Reading. At approximately 18.55, an attacker entered the Gardens with an 8" bladed concealed knife. The attacker waited until he was close to the group and then commenced his attack with ruthless speed and brutality. David had no chance to react let alone defend himself. The attacker stabbed David in the left side of his upper back causing a penetrating wound to the left chest space, from which injury he lost consciousness and died extremely rapidly. David promptly received all appropriate life support efforts from, in turn, members of the public, the police, ambulance and air ambulance services, but his injuries were not survivable. Two of David's friends were also killed in the attack, another friend in David's group and two other members of the public in a nearby group were also stabbed, but survived. The attacker escaped from the Gardens but was detained.

4 Conclusion of the Coroner as to the death

(1) David Wails was unlawfully killed. The sole direct cause of David's death was the premeditated actions of the attacker. The attacker's intention, for the purpose of advancing his extremist Islamic cause, was to kill as many people as possible in as short a time as possible, and thereafter to escape. The attacker was not suffering from a mental disorder or mental disability which lowered his degree of culpability. The attacker met the diagnostic criteria for an anti-social personality disorder and for moderately severe substance misuse disorder, but did not have any major mental illness. The attacker had combat training and experience having as a teenager trained and fought as a member of the extremist Islamic militia Ansar al-Sharia in Libya. The attacker used that combat experience to target a vulnerable area on each of the three deceased when he stabbed them.

(2) David's death was contributed to by the failure of multiple agencies adequately to:

- share intelligence concerning the attacker's extremism;
- assess the resulting risk, taking into account both the full intelligence picture concerning extremist views and his tendency towards impulsive violence against a background of personality disorder; and
- act and plan in response to the risk in a sufficient and coordinated way.

The failures principally involved the Counter Terrorism Police, the Prison and Probation Service, the Berkshire Healthcare Foundation Trust, and related shortcomings in the functioning of the Prevent, Pathfinder and MAPPA processes. There was a tendency to underestimate the attacker's extremist risk because of his personality disorder and some symptoms of Post Traumatic Stress Disorder. Had intelligence been better shared and the risks properly assessed, the agencies would have viewed the attacker as a very high risk in the community, particularly if his conduct or stability in the community

Record of Inquest

deteriorated. The attacker was released from custody on 5 June 2020. The combination of the attacker's relapse into cannabis use and his making threats on 19 June 2020 would have justified an urgent recall to custody. Because of the earlier multi-agency failures in risk assessment and information sharing, the risk posed by the attacker was not fully understood by probation and the threats made on 19 June were not passed on to probation by the police. As a result, recall to custody was neither actioned nor seriously considered. Prompt action to recall the attacker to custody would probably have avoided the attack.

(3) There were failures by Berkshire Healthcare Foundation Trust (mental healthcare in the community) and Midlands Partnership Foundation Trust (secondary mental healthcare in prison custody) in the provision of mental healthcare to the attacker. BHFT should have provided a care co-ordination role to optimise the prospect of the attacker achieving sufficient stability to be able to enter longer term treatment for his personality disorder and symptoms of PTSD. MPFT should have taken steps to retain the attacker on the waiting list for psychological treatment or restore him to that waiting list. Consistent case-management and long-term therapy had a real potential to reduce the attacker's aggressivity, impulsivity and substance abuse, along with his offending. However, the extent to which this would have impacted on his extremist beliefs is more difficult to determine. Accordingly, it is possible but cannot be said to be probable that these failures contributed towards the attack.

(4) There was a series of failures by Home Office immigration teams in managing the attacker's immigration status. These included not taking sufficient pro-active steps to seek to achieve his removal, granting him the wrong type of limited leave and inappropriately seeking the discontinuance of legal proceedings. However, because of the security situation in Libya, there was never a sufficient window of opportunity to secure his removal back to Libya that was both practicable and lawful. These failures, while serious, did not contribute towards the attack.

(5) A number of organisations and individuals did all that they could in relation to the attacker and the effects of his attack. They included the British Red Cross, the Reading Refugee Support Group, and the ambulance and police services and many members of the public in responding to the attack itself. They also included a BHFT crisis team consultant who pressed the case for care co-ordination and the attacker's probation officer who worked tirelessly to address the risks and issues arising from the attacker's offending.

5 Further particulars required by the Births and Deaths Registration Act 1953 to be registered concerning the death

(a) Date and place of birth: **15 August 1970** **Consett, County Durham**	
(b) Name and Surname of deceased: **David WAILS**	
(c) Sex: **Male**	(d) Maiden surname of woman who has married: **--------**
(e) Date and place of death: **20 June 2020** **Forbury Gardens, Reading**	
(f) Occupation and usual address: **Senior Principal Scientist,** **Flat 2, Malcolm Place, Caversham Road, Reading, Berkshire**	

Record of Inquest

Signature of the Coroner:

Adrian Fulford

Sr Adrian Fulford PC KC, Nominated Judge Coroner