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**

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

REPORT TO THE LORD CHIEF JUSTICE REGARDING JUDICIAL TRAINING IN FIREARMS LICENCING

	THIS REPORT IS BEING SENT TO: **The Lord Chief Justice, The Right Honourable the Lord Burnett of Maldon** This document is but one of a number of prevention of future death 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 be copying 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 particular, the jury determined that there had been a serious failure at a national level by the government, Home Office and the National College of Policing to implement the recommendation from Lord Cullen's Report into the shootings in Dunblane in 1996 and subsequent HMIC reports in 2015 to provide training to those involved in licencing decision making. The need for training has also been reported on in an earlier 'prevention of future deaths report' made by the Senior Coroner for Surrey in 2019. I heard evidence that, in the Devon and Cornwall Police area, in approximately 50% of appeals to the Crown Court against the Chief Officer of Police's decision to revoke or not to grant a firearms licence the appellant succeeds. I was presented with a case summary of a recent case in Devon and Cornwall. This arose from an incident where a certificate holder (AB) was arrested after his wife (XY) phoned the police saying he was drink driving. In the course of the arrest, AB assaulted the police officer. At the scene, XY and their adult offspring (CZ) made allegations of alcohol-related domestic arguing and controlling behaviour. More concerningly, XY

reported a specific threat made by AB to CZ to enact a 'suicide pact' potentially using his shotgun. The guns were seized that night. XY refused to make a statement and sought to retract her view that the guns should have been seized. CZ later also referred to concerns of suicide but both XY and CZ said they were not concerned for their safety. Concerns of domestic abuse (including coercive and controlling behaviour) were raised. The certificate was revoked. Not at all unusually, both XY and CZ then recanted their allegations on the stand. The Court found that (a) the certificate holder had not given an account of what had happened, (b) he had had a 'serious' 'one off argument' with his wife, but (c) it was 15 months beforehand and did not demonstrate intemperate habits. The Court gave back the gun.

I was informed that the case is not untypical and demonstrates two problems that the Chief Constable strongly suspects are national issues:

(1) The Court appears to have taken an approach that none of the allegations were 'proven' on the balance of probabilities and therefore they could not be taken into account; and
(2) The Court's approach to risk and suitability appears to have set a high threshold for revocation when considerations of violence and intemperate habits are in play.

Under the 1968 Firearms Act appeals on the merits are *de novo* hearings in the Crown Court where the Court must have regard to the statutory guidance (s.44(3A)). Understanding of the guidance and its application is therefore of significant importance on appeal.

I have written separately to the Home Secretary about a potentially misleading reference to the application of the balance of probabilities test when making licencing decisions within the current Statutory Guidance to Chief Officers of Police that the Home Office re-issued on 14 February 2023. A copy of that report is enclosed for your information.

I understand that at present Crown Court judges are not required to undergo training in firearms licencing, and specifically not required to undergo training regarding the application of either the 2022 Home Office Guidance or the additional 2023 Statutory Guidance, before they are able to hear appeals under s.44 of the 1968 Act.

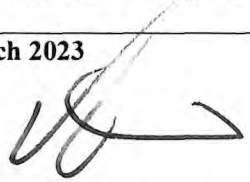
In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

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

I am concerned that judges may be unfamiliar with the nature of the decision being made in licencing cases which is a risk decision through the prism of suitability and does not require facts to be proven.

I am concerned that there may be a need for training of judges in respect of applying the recently re-issued statutory guidance for firearms licensing and in the conduct of suitability assessments.

Greater training and education to all persons involved in firearms licencing decision making would reduce the risk to the public of a gun being in the hands of an unsuitable person.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 persons or organisations 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 I M Arrow**

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

REPORT TO THE HOME SECRETARY & MINISTER FOR POLICING REGARDING FIREARMS LEGISLATION

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **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 This document is but one of a number of prevention of future death reports that I am issuing following these inquests. 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 inquests 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 the 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** to me are as follows – I am concerned that the 1968 Firearms legislation requires root and branch reform.

1. Legislative presumption and its impact upon firearms licencing culture

The presumption in the legislation is that a firearms certificate (s.27(1)) and a shotgun certificate (s.28(1)) "shall be granted" unless the various requirements are not met.

I am concerned that this approach is at odds with public safety and the fundamental principle that owning a gun is a privilege and not a right. I was informed that this contributed to the culture within the Devon and Cornwall Police Firearms and Explosives Licencing Unit (FELU) of tending to default in favour of a right of applicants to have a firearm/shotgun.

I am concerned that the public would be better protected if the legislation provided that a certificate "shall not be granted" unless the applicant has satisfied the relevant Chief Officer of police that they are safe to hold a gun of any type.

2 . Harmonising the legislative criteria for firearms and shotguns

The evidence before me was that:

(i) a shotgun is no less lethal a weapon than a firearm if misused;
(ii) the distinction between s.1 firearms and s.2 shotguns in the Firearms Act 1968 has contributed to a perception that shotgun licensees pose less risk to themselves and the public and hence that an application for a shotgun certificate demands less rigour;
(iii) the need to provide only one referee for the grant of a shotgun led to less information regarding the perpetrator's risk than might have otherwise been obtained being available for consideration;
(iv) the absence of an ability to place conditions on the grant of a shotgun licence meant that the proposed storage of the perpetrator's weapon at a different address with a family member, could not be enforced. Having granted the licence, the police remained wholly unaware that the family member was not holding the perpetrator's shotgun;
(v) the perpetrator was able to purchase a pump action shotgun which was an extremely unusual type of weapon to have for his declared intention of going clay pigeon shooting;
(vi) the perpetrator was able to purchase a very large quantity of ammunition, mostly OOB cartridges of the type used for shooting large game, this was not appropriate ammunition to use for his declared use of clay pigeon shooting.

The continued distinction between s.1 firearms and s.2 shotguns in respect of the conditions for granting a licence was not supported by any of the Firearms and Explosives Licencing Unit staff numerous police officers, of all ranks, who gave evidence about this issue.

As a consequence of the different statutory approaches

(i) Applicants for shotgun certificates are not required to show a good reason in order to possess such a weapon.
(ii) No conditions can be placed on the type of shotgun or ammunition that can be purchased/possessed or on the conditions under which they must be stored.
(iii) Only a single referee is required before issuing a shotgun certificate, thereby

reducing the opportunity to obtain relevant background information about the applicant.

I am concerned that whilst the criteria for issuing shotgun licence remain less stringent than those for holding s.1 firearms, a misleading impression of the potential fatality of each type of weapon will continue to affect the perception of and attitude to risk amongst Police Firearms and Explosives Licencing Units (FELUs) and public safety will be compromised.

3. Absence of a power to suspend firearms/shotgun certificates pending a review of suitability

The evidence before me was:

(i) If concerns were raised around the suitability of a person to hold a certificate during that certificate's lifetime, such as reported domestic abuse, it was good practice to seize the certificate, gun(s) and ammunition so that a decision regarding the need for revocation of the certificate could be taken in a measured manner whilst the weapon was not in the holder's possession.
(ii) Whilst many licence holders will voluntarily surrender their weapon and ammunition, that will not always be the case.
(iii) There is no provision with the Firearms Act 1968 to empower police officers to enter private property to seize firearms, shotguns, ammunition or certificates, pending a review of suitability unless a warrant is obtained pursuant to s.46 of the Act.
(iv) Whilst police may use powers under the Police and Criminal Evidence Act 1984 (PACE) to enter a property in defined circumstances, such as where there is a threat to life or limb, this would still not permit seizure of a shotgun/firearm absent an ongoing suspicion of a relevant criminal offence to provide a basis for seizure.
(v) There will be cases where a person refuses to surrender their weapon and there is no, or no good, legal basis for seizure under PACE.

I am concerned that when there is reason to be considering the suitability of a current certificate holder the public is left at unnecessary risk by the absence of primary legislation providing the police with a power of immediate seizure of firearms, shotguns and ammunition so as to immediately remove the risks relating to the use of the weapon.

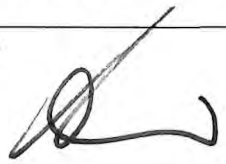
I am concerned that the present requirement to obtain a magistrate's warrant creates a delay during which time both the public and holder of the weapon will remain at risk.

4. Mandatory prohibitions

The evidence before me was:

(i) The current statutory prohibitions under s.21 Firearms Act 1968 - which (1) prevent a person sentenced to more than three years imprisonment ever holding a firearm, and (2) prevent a person released from a prison sentence of three months or more from holding a firearm within the following five years - no longer reflect the realities of criminal justice system disposals and the wide spread use of restorative justice and diversion schemes for violent offenders (among others).
(ii) Prohibitions that may have been appropriate in 1968, by reference to length of prison

	sentence rather than based upon the criminal act, will, today, allow violent offenders who have not been prosecuted for their admitted criminal activity, or who have been given community disposals, to apply for and successfully obtain a firearms licence. I am concerned that continued application of the prohibitions established in 1968 in the context of modern day criminal disposals, and continuance of a system that does not link the prohibition on holding a licence to the **responsibility for particular categories of criminal acts** (rather than the length of prison sentence imposed if convicted) will leave many firearms and shotguns in the hands of dangerous offenders who should (and would, previously when criminal justice diversion schemes were not ubiquitous) have been barred from holding a weapon . My concerns above were shared, and changes to the legislative proposals endorsed by many of the witnesses at these inquests. The position in Northern Ireland under the Firearms (Northern Ireland) Order 2004 (SI 2004/702) is illuminating. Under the 2004 Order: • there is no distinction between firearms and shotguns for the purposes of issuing a certificate; • there is no presumption in favour of grant; • a license can only be issued if the Chief Officer is positively satisfied that the applicant is safe to be entrusted with a firearm, is a fit person, and has a good reason for possessing each gun to which the certificate relates; • two referees are always required; and • the Order sets out minimum standards as to the information to be provided by referees. **5. Conditions** I am concerned that the absence of any ability to place conditions on the grant of a shotgun licence is putting members of the public, and shotgun holders themselves, at risk. It was drawn to my attention that under the Northern Irish statutory instrument, a wide range of conditions can be imposed, regardless of the type of gun to which the certificate relates (including, for first-time applicants, a condition that they may only use their weapons under the supervision of an experienced certificate holder). Had these powers been in place in England and Wales, the expectation of the FELU at the time of the grant of perpetrator's shotgun licence, that it would have been held by his family member, could have been made a formal condition on issuing his licence and these unlawful killings may then have been avoided.
	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 I M Arrow**

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

REPORT TO THE HOME SECRETARY & MINISTER FOR POLICING
REGARDING HOME OFFICE FIREARMS GUIDANCE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **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 This document is but one of a number of prevention of future death reports that I am issuing following these inquests. 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 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: **Home Office Guidance** I am concerned that the current Home Office Guidance published in November 2022, and additional Statutory Guidance for Chief Officers of Police that was updated and re-issued during these inquests (on 14 February 2023) may benefit from review in the light of evidence heard at these inquests.

1. Clarification of the degree of certainty applicable to firearms licensing decisions

I heard evidence from a Home Office witness who expressed the view that it would be 'very difficult' for a firearms licencing officer considering an application to take into account any matter which could not be proved on the balance of probabilities.

It is of concern that this suggestion as to the required the degree of certainty when assessing overall risk appeared to be premised on a misunderstanding of the underlying legal position. That misunderstanding also appears to be reflected within the recent statutory guidance on suitability that was issued on 14 Feb 2023.

It has never been a requirement of the statute, the case law, or the guidance that either the Chief Constable (or the Court if considering a firearms licencing appeal) needs to be satisfied that a matter happened on the balance of probabilities before taking it into account when assessing suitability. Nor is it the case that, if not so satisfied, the police must proceed on the basis that the alleged event did not in fact happen.

I was informed that there are legal and practical reasons for adopting this position when assessing risk. Primarily because, to best keep the public safe, these risk decisions and appeals are not predicated only on proven facts, but also on information and intelligence held or obtained by police, including medical information. I was informed that, **ultimately, all licencing decisions are risk assessments through the prism of suitability.**

The statutory test for suitability (even as currently framed) is not, therefore, based on the the balance of probabilities, and there appears to be no reason in law why licensing staff should only be able to take account of information relevant to suitability that is provable on the balance of probabilities.

The 2023 revision of the Home Office Statutory Guidance does state that what is being undertaking is a risk assessment (see §3.3). But later sets out that '*the test to be applied to assessing information regarding any behaviour or allegation that has not resulted in a conviction is the balance of probabilities*' (§3.16 and §3.26). That is then somewhat contradicted by other parts of the same paragraph and §3.27, which permits matters not proven the balance of probabilities to be 'taken into account'. I am concerned that this is at best confusing and at worst misleading when the correct approach to assessing risk does not require the degree of certainty more familiar in civil litigation.

I am concerned that the statutory guidance does not clearly reflect that the issue of risk and suitability to hold a certificate should be based on the totality of the risk information available to the Chief Constable/Court, applying appropriate weight to that information on a case-by-case basis and does not require facts to be proven on balance of probabilities.

2. Guidance as to referee's responsibilities

The number of referees required by statute is addressed in another prevention of future deaths report.

During the inquests I heard evidence from the referee involved in the perpetrator's application. She stated that she had not done the task before and had no knowledge of the exercise the police had to do in relation to licencing. She assumed she would not be the only person asked for information relevant to the licencing decision. She had not mentioned some information that may have been relevant to risk as she was not asked about it. She said she was not given any sort of referee's check list regarding what information should be supplied to firearms enquiry officers by referees. Had there been one, she said, it would have made her task much easier as it would have given her something to assist with

understanding which matters were relevant her role.

The jury found that the referee's tasks and responsibilities were not made clear to her and insufficient inquiries were made of the referee.

Police witnesses also confirmed in evidence that, in their opinion, having a referee's check list or similar document would improve the prospect of Firearms and Explosives Licensing Unit (FELU) staff eliciting relevant risk information from a referee.

In respect of the current Home Office Guidance my concern is that there remains today little guidance as to how and what information is obtained from referees. The Home Office '*Guide on Firearms Licensing Law*' published in November 2022, does not address referee's responsibilities at all. In the February 2023 '*Statutory Guidance for Chief Officers of Police*' it is simply stated that:

> *'As a minimum, the referee should be made aware of the application, so that he or she has the opportunity to inform the police of any concerns. The referee may also be asked about any matter relating to the applicant's suitability to possess firearms.'*

I note that the requirements in relation to referees are said to still be '*under review*' in the 2023 update to the statutory guidance that was published during these inquests. I am nevertheless concerned that in the absence national guidance there will be little consistency in how FELU staff approach this aspect of the suitability assessment. As such the public remain at unnecessary risk whilst there is no national guidance as to the nature and form of enquiry that should be made of referees.

I am concerned by the absence of a check list or similar document and the absence of any requirement for the referee to give a written declaration that they have disclosed all relevant facts to the Firearms enquiry officer.

I am similarly concerned that the absence of a national standard enquiry form allows for inconsistency between FELUs in how staff approach the collection of relevant information, thereby impoverishing the assessment of risk to the public.

3. Level of application fees

Whilst I understand that a review of firearms licencing application fees is underway, evidence provided to me during the inquests was that the process is not self-funding at present.

As the jury determined: "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."

I am concerned that unless and until the firearms licencing process becomes self-funding and the calculation of fees charged *includes* the costs of providing adequate training to FELU staff in addition to the costs of the day to day running of the service, there will remain an unacceptable risk that licensing units will be under-resourced, with insufficient staff who are inadequately trained making rushed and ill-informed decisions.

	4. Medical records and firearms reminders I was made aware that the current position is that under the current Home Office Guidance, and with the agreement of the BMA, there is now a process in place for a computerised firearms reminder to be placed on GP records to remind the GP that they may need to contact the police if a person begins to suffer from a relevant medical condition. Although reflected in the statutory guidance this is not a mandatory process, rather this is a position agreed in a memorandum of understanding between the Home Office, Police and British Medical Association in July 2019. In this case the perpetrator's mother had contacted a mental health emergency care triage service a few weeks before the shootings. She reported that she had concerns about his mental health and recent self-harm. However, that organisation was not aware that her son was a firearms certificate holder, and the GP was also unaware of this contact. I am concerned that unless the process that has recently been agreed with the British Medical Association in respect GPs is extended to cover placing firearms reminders on <u>all</u> medical records within a unified records system, and in particular, mental health records, then important information will not come to the attention of police if a certificate holder begins to suffer from a relevant medical condition or a relevant condition worsens significantly, and this may affect the person's ability to possess a firearm safely.
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 I M Arrow**

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

REPORT TO ALL CHIEF CONSTABLES IN ENGLAND AND WALES REGARDING THE RETURN OF WEAPONS AFTER REVIEW OF SUITABILITY

	THIS REPORT IS BEING SENT TO: **All Chief Constables in England and Wales** 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.

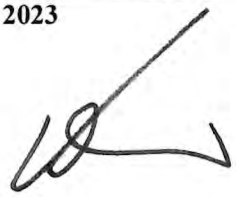
The death was caused by the fact that the perpetrator had a lawfully held shotgun. The following contributed to this position.

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	**<u>CORONER'S CONCERNS</u>** Evidence I heard at these inquests (from a Chief Superintendent from Devon and Cornwall Police) was that, as a result of changes in the procedures and systems in Devon and Cornwall since these events in 2021, the rate of refusals of grant applications in Devon and Cornwall is now around 6%. This is, by a significant margin, greater than the national average rate of refusals and revocations which, according to published figures, is under 3%. I was also informed that, in the wake of the shootings in Keyham, in 2021 the Home Secretary wrote to all Chief Constables in England and Wales and required them to *'carry out a full review of all certificates that have been seized, refused, revoked or surrendered in the past twelve months, and subsequently approved by the police'* and *'confirm that you are satisfied that the processes that you follow in terms of returning a certificate are appropriate when set against the current Home Office guidance and legislation.'*

	I was informed that all police forces then reviewed their decisions to return a weapon in the previous year and only one police force (not Devon and Cornwall Police) identified any case where firearms had wrongly been returned to certificate holders in the previous year. I was told there were 9 cases identified in that one force. Whereas the remaining 42 forces (including Devon and Cornwall Police) found no incorrect decisions to return a certificate had been made. However, it appears that a recent more stringent review of their own cases by Devon and Cornwall Police in preparation for these inquests had now revealed that 12 firearms certificates had been wrongly returned when the certificates should have been revoked. As the Chief Superintendent stated in evidence, it is unlikely that only two police forces in England and Wales had wrongly returned a certificate in the year concerned. Given the dearth of training available to FELU staff nationally (which I have addressed in an accompanying report) I am concerned that in other police force areas, weapons may remain in the hands of individuals who pose a danger to the public. The **MATTERS OF CONCERN** are as follows. In the light of this information I am concerned that the information from those 41 police forces who indicated that they had made no incorrect decisions to return a weapon/certificate may need to be further tested and explored. I am concerned that the figures provided to the Home Secretary in 2021 may not reflect the accurate position, and that if sufficiently stringent checks are performed these may reveal other cases where a firearm or shotgun certificate had been seized, refused, revoked or surrendered but was subsequently issued/returned in circumstances when the certificate should not have been approved. I am concerned that if there are other cases that were not subject to a proper or thorough review of the risk of returning the weapon then the person may continue to have a firearms/shotgun certificate and hold weapons in circumstances that place the public and the licence holder themselves at risk. I am concerned that in the light of the lessons learned in the Keyham inquests of the attitude towards risk, a further review of all certificates seized, refused, revoked or surrendered and then subsequently approved over the past five years may be required to be assured of public safety.
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 I M Arrow**