IN THE EAST LONDON CORONER'S COURT

BEFORE HM SENIOR CORONER, MR GRAEME IRVINE

THE INQUEST TOUCHING UPON THE DEATH OF JADEN MOODIE

CORONER'S RULING ON RESUMPTION

1. Like so many cases before the Coroner's Court, this case involves a significant tragedy, which can only evoke sympathy towards Jada Bailey and her family. It is noted and understood that Ms Bailey's motivation for making these submissions to the court for resumption of the inquest are, in themselves noble, namely that lessons are learned from Jaden's death, and that changes may occur which would spare others from the pain that she has suffered.

2. Jaden was a 14-year-old child at the time of his death. Jaden died on 8th January 2019 at an area outside 7 Bickley Road, E10. Jaden had been riding a moped along Bickley Road when he was struck by a moving vehicle. Persons decamped from the vehicle, approached Jaden and repeatedly stabbed him, causing his death. Jaden's death was confirmed at 19.09 hrs. The death was referred to HM Coroner.

3. A forensic post-mortem was authorised and was conducted on 9/01/2019, the autopsy disclosed a cause of death of;
    a. Ia. Hypovolemic Shock

b. Ib. Stab Wounds to the Torso.

4. An inquest was opened by HM Coroner Nadia Persaud on 18/1/2019 at the East London Coroner's Court.

5. On 19/01/2019 Ayoub Majdouline was charged with the murder of Jaden. The coroner's inquest was formally adjourned by HM Assistant Coroner Ian Wade KC on 2/4/19 pursuant to Para 1(6) Schedule 1 ("the Schedule") to the Coroners and Justice Act 2009 ("the Act"). A Form 120 was issued.

6. On 25/11/2019 the trial commenced at the Central Criminal Court and after a two- and half-week trial, the Jury returned a majority verdict and found Ayoub Majdouline guilty of the murder and Possession of an Offensive Weapon.

7. On 24/12/19 a coroner's certificate confirming that the inquest was not to be resumed was issued by me in accordance with Schedule 1 to the Coroners and Justice Act 2009.

8. Immediately following Jaden's murder, the relevant local authority, Waltham Forest, agreed that the criteria outlined in the statutory guidance for undertaking a serious case review had been met. The Safeguarding Children's Board (SCB) for Waltham Forest commissioned John Drew, a former children's social worker to produce a Serious Case Review ('SCR') which was published in May 2020.

9. The SCR fell short of asserting that Jaden's death was predictable but made factual findings of 8 areas in which learning could be made.
    a. *Child C spent all but 3 of his last 22 months out of school and for much of this there was limited adult guidance or supervision in regard to how he spent his time.*
    b. *The response to Child C while detained in Bournemouth and then on his return from there in October 2018 did not capitalise on a 'reachable' moment for a child who was clearly being criminally exploited, and nor was all the information available from the authorities in Bournemouth transferred to their counterparts in Waltham Forest.*
    c. *By early January 2019 there were considerable numbers of professionals involved with Child C and his family, creating obvious risks of duplication and confusion.*
    d. *Information about the first two gun-related incidents involving Child C. (in 2016 and 2017) was not shared by the Nottinghamshire Police with other agencies, and nor did*

Nottinghamshire Police share information about the threats made against Child C in the summer of 2018.

e. *There was a delay in processing DE's application for a place for Child C at a Waltham Forest High School in May 2018.*

f. *The initial response to DE's application for housing in Waltham Forest was slow and no new action was taken following DE's request that her application for rehousing be reopened by Waltham Forest in August up until the end of October 2018.*

g. *The Housing Service was not engaged in multi-agency discussions about how to respond to the criminal exploitation of Child C.*

h. *The initial gathering of background information about Child C carried out by the Waltham Forest Multi Agency Safeguarding Hub (MASH) in October 2018 was incomplete and the Waltham Forest High School should have been alerted to the involvement of one of their pupils in these events. While the overarching approach of the partnership's response to children who are criminally exploited is sound, and in particular, contextualised safeguarding is well described in the Waltham Forest safeguarding partnerships' Adolescents Practice Guide ('Safeguarding Adolescents: A Practice Guide') there may be learning for the partnership from a number of specific features of Child C's case in respect to speed of initial response, assessment and response to contextual safeguarding issues, and awareness of the threat of drug debt bondage.*

10. On 12/11/19 Ms Bailey made a formal complaint to the Metropolitan Police Services (MPS) regarding a failure to take safeguarding steps to prevent the death of Jaden. The complaint resulted in a Public Complaint investigation report ('PCIR') dated 6/7/2021.

11. On 8/8/21 an appeal was received by the IOPC from Ms Bailey citing an inadequate investigation hampered by inadequate disclosure of documents, leading to conclusions unsupported by evidence.

12. On 28/1/22 the appeal was partially upheld by the IOPC in seven areas, and a further investigation resulted which reported on 13/4/23 (The Public Complaint Addendum Report – 'PCAR') upholding two of those seven areas, specifically;

    a. *TOR 6 Jaden Moodie was not suitably safeguarded by the Metropolitan Police Service following his move from Nottinghamshire to London in August 2018, and,*

    b. *TOR 7 Jaden Moodie was not suitably safeguarded by the Metropolitan Police Service following his arrest by Dorset Police in October 2018.*

13. On 14/6/23 Ms Bailey's representatives confirmed that they did not intend to make any further appeal to the IOPC following the MPS re-investigation and invited me to resume the inquest. I asked for written submissions upon the point which were received on 27/11/23.

14. The submissions set out on behalf of Ms Bailey are lengthy, running to some 17 pages, I have taken time to reflect upon them and the evidence available to the court, including the SCR, the PCIR and the PCAR.

15. The family suggest that there exists sufficient reason to resume the inquest into Jaden's death pursuant to para 8(1) Sch 1 CJA 2009 as;
    a. The circumstances of Jaden's death engage the Article 2 procedural obligation, requiring a s.5(2) Middleton inquest, following arguable breaches of the state's operational and systems duties under article two;
    b. The article two procedural obligation has not in this case been discharged through other concurrent, state investigations.
    c. The serious public interest concerns raised by Jaden's death require a broad inquest examining how Jaden came to die.

16. Ms Bailey firstly asserts that there has been an arguable breach of the operational duty on the State to take preventive measures to protect an individual whose life is at real and immediate risk of which the State knows or ought to know (Osman v UK (2000) 29 EHRR 245, §115).

17. She argues that there is persuasive evidence (identifying 16 incremental events) to support the fact that between 2016 and his death, Jaden was a child at risk of serious harm from criminality and exploitation. The family submissions argue that during the currency of this period, Jaden was subject to threats to his safety including fatal threats.

18. Critically, the family go on to assert the State agencies responsible for addressing the serious risks Jaden faced from child exploitation was arguably inadequate, setting out (a non-exhaustive list of) 12 omissions attributable to the state actors between 2018 and his death.

19. The family rely upon 6 factual findings of the SCR and 4 more found within the PCAR to illustrate the point above.

20. In addition to the arguable breach of the operational duty, Ms Bailey contends that there arguably exists a breach of the systems duty pursuant to Article two, *'a framework of laws, systems, precautions and procedures which will, to the greatest extent reasonably & practicable, protect life'.* The family reason that the acts and omissions listed above imply systemic deficiencies which resulted in an inadequate state response. They point to findings both in the SCR and PCAR that indicate that flaws in communication and sharing of information within a multi-agency protection system tend to a systemic failure.

21. The family reject the suggestion that the other investigations into Jaden's death;
    a. The criminal trial,
    b. The SCR,
    c. The PCAR,

    individually or taken together, discharge the state's procedural obligation under article two to investigate a death.

22. The family assert that the criminal trial was limited in its scope, focussing largely on physical causation of Jaden's death and the motivations of the assailants. It did not involve the family in any interactive way.

23. Both the SCR and police complaint reports, the family say, were incapable of fulfilling the objective of the procedural obligation in the sense set out in Jordan v UK (2003) 37 EHRR 2.
24. The SCR was held in private, did not have powers to compel witnesses or disclosure, did not have a mechanism to challenge or test evidence and the family were unable to actively participate in the process. The family argue that by analogy the criticisms levelled at the SCR in this case are the same as those raised regarding a Domestic Homicide Review ('DHR') in R (Silvera) v Her Majesty's Senior Coroner for Oxfordshire [2017] EWHC 2499 (Admin).

25. The police complaint reports are, the family contend, similarly flawed for the same reasons. Additionally, the PCIR and the PCAR were undertaken by Metropolitan Police Officers, not the IOPC and therefore could not be said to be independent.

26. The final strand of the family submission is contingent upon the court rejecting the twin arguments presented under article two. Here the Family argue that even if article 2 is not engaged, compelling public interest concerns demand a wide-ranging inquest examining how Jaden came to die.

27. The public interest concerns include; The family wish that an inquest is heard, The need to strive for a transparent and reasoned examination of the truth of a person's death. The need to allay public concerns, specifically the issue of harm to young people through criminal exploitation. To avoid the sole court-finding into Jaden's death being the reductive conclusion of an unlawful death as arrived at by the homicide conviction in the criminal court. The possibility of reflection and remediation that can flow from an inquest. To resume the inquest opened by Ms Persaud I must satisfy myself that there is sufficient reason to resume the inquest into Jaden's death pursuant to para 8(1) Sch 1 CJA 2009. I turn first to the arguments raised pursuant to Article Two.

Ruling

28. I accept the family's submission that the State's investigative obligation under Article 2 ECHR was engaged on the basis of potential breach by the police of their operational duty to safeguard Jaden's life. The low threshold of arguability is made out here by the admitted failings of the MPS combined with the findings of the SCR.

29. I reject the argument that the investigatory obligation was engaged on the basis of potential breach by the police and other agencies of the systemic duty to safeguard Jaden's life. Such a duty operates at a high level, the "duty to put in place a legislative and administrative framework to protect the right to life, involving effective deterrence against threats to life, including criminal law provisions to deter the commission of offences, backed up by a law enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions" (Van Colle v Chief Constable of the Hertfordshire Police [2009] 1 AC 225 at para 28. In this case numerous systems were in place during the material time. The argument that the systems in place can be assessed as insufficient due to the fatal outcome for Jaden is a syllogism.

30. I now turn to the question of whether the state has satisfied the enhanced procedural obligation under Article two? Here the question I must pose is whether all the other investigative procedures of the state have collectively satisfied the requirements of the procedural obligation (see Goodson v HM Coroner for Bedfordshire [2004] EWHC 2931 (Admin) at paragraph 59 (iv) and (vi)). I remind myself that it is necessary for the Coroner to consider "the totality of available procedures", including public investigations and any potential for a civil claim: R (AP) v HM Coroner for Worcestershire [2011] EWHC 1453 (Admin), [95].

31. The decision of a Coroner on whether or not to resume an inquest has been described as one "of a highly discretionary character". I remind myself of the guidance provided by the Chief Coroner in Law Sheet No.5 which asserts that the wide discretion a Coroner has in making decisions, "emanates from the inquisitorial nature of the coroner's inquiry." (R v South London Coroner, ex parte Thompson (1982) 126 SJ 625). There must be a good reason for me to exercise my discretion in a particular way, both in fact and in law. As Lord Greene MR said in the Wednesbury case "… a person entrusted with a discretion must, so to speak, direct himself properly in law. He must call his own attention to the matters which he is bound to consider. He must exclude from his consideration matters which are irrelevant.'."

32. There is no prescriptive approach to the form of an Article 2 investigation and, although its precise constituents will vary from case to case, the minimum requirements were set out in Jordan v United Kingdom (24746/94) (2003) 37 EHRR 2, [2001] 5 WLUK 158.

33. I have considered and adopt the ratio of Garnham J in R (on the application of Sharon Grice) v Her Majesty's Senior Coroner of Brighton and Hove v The Chief Constable of Sussex Police, Sussex Partnership NHS Foundation Trust [2020] EWHC 3581 (Admin) [84-85].
    a. No particular procedure had to be adopted in order to fulfil the Jordan requirements. The requirements can be satisfied by a set of separate investigations, rather than by a single, unified procedure.
    b. The requirement for the family of the deceased to be involved in the investigation did not mean the investigating authorities had to satisfy every request for a particular step to be taken.
    c. The requirement for public scrutiny did not invariably require a public hearing nor did it mean that the family had to be able directly to test the evidence.
    d. There was no requirement that each element of the investigative procedure met each one of the tests.

34. I have sought and secured disclosure to allow me to properly assess the nature and scope of; the criminal trial, the SCR, the PCIR and the PCAR, having considered that material I find that the state has: acted of their own motion to investigate; the cumulative investigation process was independent, effective and reasonably prompt; the investigations did have a sufficient element of public scrutiny of its processes and results to secure accountability; and that there was involvement of the next of kin to the extent necessary to safeguard their legitimate interests. As such, I do find that the state fulfilled its obligation under the enhanced investigative obligation through the totality of the investigations set out above. In simple terms I pose myself the

question, have the cumulative investigations covered the likely scope of an inquest and my answer is that that they have and indeed have gone beyond the remit of the type of inquest described by the Lord Chief Justice in R (Morahan) v HM Assistant Coroner for West London [2022] EWCA Civ 1410 "an inquisitorial and relatively summary process. It is not a surrogate public inquiry.".

35. I go on to ask myself whether the conclusions of any inquest could provide valuable conclusions (primary conclusions and a Regulation 28 report) that would go beyond the conclusions reached in the other investigations? Firstly, the limitations placed upon me mean that any primary conclusion at inquest could not be inconsistent with the result of the criminal trial and therefore "Unlawful killing" would be the most appropriate conclusion.

36. Secondly, a Regulation 28 report is simply a report not a ruling, it is toothless to the extent that a coroner cannot proscribe a solution to the concern identified, require specific performance of remediation or even demand that the report is responded to. Other inquiries into Jaden's death have been able to make recommendations and require action.

37. I ask myself is this submission intended to lead to an inquest that would relitigate the criminal trial? I do not find that to be the case.

38. Finally, I ask myself what are the family wishes? There clear wish is that a Middleton inquest is heard into the death. I value their submissions and understand their depth of feeling but I note that the family wishes are not the determinative issue. I am not satisfied, for the reasons set out above, that there is sufficient reason to resume the inquest into Jaden's death pursuant to para 8(1) Sch 1 CJA 2009.

Mr Graeme Irvine
HM Senior Coroner for East London
18th March 2024