

<p>1 Friday, 3 December 2021</p> <p>2</p> <p>3 INDEX</p> <p>4</p> <p>5 Summing up (continued)2</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p style="text-align: center;">Page 1</p>	<p>1 tab 11, and page 6. This was the day that Mr and</p> <p>2 Mrs Whitworth and Ricky came here to Barking, first of</p> <p>3 all to see where Daniel's body had been found, but also</p> <p>4 to discuss the note. You will remember the evidence was</p> <p>5 that Mr Schamberger agreed that the family should visit</p> <p>6 Barking, including Ricky, but he only authorised that</p> <p>7 Mr Whitworth should be shown the note. He now agrees</p> <p>8 that it would have been extremely valuable if the note</p> <p>9 had been shown to Ricky at that time, and you will</p> <p>10 remember, winding the clock forward, Ricky didn't see it</p> <p>11 until the inquest.</p> <p>12 They came to Barking, Ricky drove you will remember.</p> <p>13 Mr Whitworth thought that they brought with them</p> <p>14 a father's day card in order for the handwriting of</p> <p>15 Daniel to be compared with the note. As you know, Ricky</p> <p>16 was excluded from the meeting, he was not shown the</p> <p>17 note, despite the fact that Mr Whitworth was suggesting</p> <p>18 that it should be shown to Ricky that day.</p> <p>19 The evidence from Mr and Mrs Whitworth was that they</p> <p>20 were left with the impression that expert handwriting</p> <p>21 evidence was going to be sought and they say they were</p> <p>22 told by Mr Slaymaker that we would then "know one way or</p> <p>23 the other".</p> <p>24 Mr Slaymaker disputes that he told the family that,</p> <p>25 he says that he doesn't recall any discussion about</p> <p style="text-align: center;">Page 3</p>
<p>1 (9.30 am)</p> <p>2 (In the presence of the jury)</p> <p>3 Summing up (continued)</p> <p>4 THE CORONER: Good morning, members of the jury.</p> <p>5 Before we go back to where we were at the end of</p> <p>6 yesterday, can I just ask you to go behind divider 10,</p> <p>7 please, of the white bundle and go to page 5, the date</p> <p>8 is 8 July 2014.</p> <p>9 The topic is the issue which has been described as</p> <p>10 Mr McCarthy stepping back and Mr O'Donnell replacing him</p> <p>11 as the senior investigating officer in relation to the</p> <p>12 Anthony Walgate investigation.</p> <p>13 I have already reminded you that the evidence is</p> <p>14 that it was not unusual and is not unusual for</p> <p>15 an unexplained death to be investigated or overseen by</p> <p>16 a detective sergeant, but I just wanted to add a little</p> <p>17 flesh to that and remind you that Mr McCarthy's evidence</p> <p>18 was that he was heavily occupied with other important</p> <p>19 jobs, including taking on the community safety unit,</p> <p>20 together with his other onerous responsibilities for</p> <p>21 example for case progression and that may be relevant to</p> <p>22 his decision to, what has been called stepping back.</p> <p>23 I just wanted to add that flesh to that particular piece</p> <p>24 of the jigsaw.</p> <p>25 Right, could we now move back to 30 September, at</p> <p style="text-align: center;">Page 2</p>	<p>1 expert handwriting evidence. He does however recall</p> <p>2 that the Whitworths were saying having seen the note</p> <p>3 that it wasn't very personal and he agreed with them</p> <p>4 about that, that there weren't personal details in the</p> <p>5 note.</p> <p>6 On that occasion, the Whitworths were not asked</p> <p>7 about events of the weekend of the dates, 27 and</p> <p>8 28 August, the night that Gabriel's body was found.</p> <p>9 They were not asked about that. They told you, had they</p> <p>10 been asked about that, they would have recalled that in</p> <p>11 fact there was a family get together that weekend which</p> <p>12 Daniel was at and he was completely his normal self and,</p> <p>13 secondly, that they couldn't think of any time around</p> <p>14 the end of August when Daniel was missing or that people</p> <p>15 didn't know where he was, but neither of those pieces of</p> <p>16 information were obtained from them at that stage.</p> <p>17 After that meeting, and after they had driven back</p> <p>18 home, Mandy Whitworth told you that she then told Ricky</p> <p>19 what was in the note. She wasn't given a copy of it but</p> <p>20 she had made some notes of what was in it and Ricky</p> <p>21 couldn't believe that Daniel could possibly have been</p> <p>22 responsible for somebody's death, particularly as he had</p> <p>23 been behaving so normally at around that time and indeed</p> <p>24 since that time.</p> <p>25 Going back to then your chronology, at 1.45 on</p> <p style="text-align: center;">Page 4</p>

<p>1 30 November, Stephen Port texted Ryan Edwards again with 2 a new telephone number. He then, as Jon Luck, sends 3 messages to Thierry Amodio, you will remember these 4 messages, about the party and also tells Thierry to keep 5 his, Jon Luck's, name out of it.</p> <p>6 This date is not on your chronology, but on 7 3 October Mr Schamberger is again chasing the actions in 8 relation to phone work and intelligence, including 9 intelligence relating to John Pape, which had still not 10 been Donna.</p> <p>11 Just to remind you, I said to you yesterday that 12 there will be overlaps between the dates in the various 13 investigations and at this stage on 6 October is when 14 Mr McCarthy is chasing the HAT referral for 15 Anthony Walgate, so that is going on in the other 16 investigation simultaneously with the dates we are 17 concerned with here.</p> <p>18 On 7 October the toxicology report for Gabriel is 19 available. The same day, Mr Slaymaker took the first 20 statement from Ricky. In that statement, Ricky said 21 that Daniel was at home with him on the night of 22 27 August. Mr Slaymaker did not ask to look at Ricky's 23 phone. Had he done so, he would have seen that there 24 were texts to and from Daniel and Ricky about Daniel 25 bringing home some cakes for their tea and Ricky</p> <p style="text-align: center;">Page 5</p>	<p>1 been taken, as I told you yesterday, by Mr Faulkner, she 2 did upload a full summary of Mr Pape's statement onto 3 the CRIS, and that is at page 54 of the CRIS.</p> <p>4 It is on the same date, 11 October, that 5 Mr Slaymaker records on the CRIS that he is going to 6 seek phone data going back to 1 August. But that was 7 never done.</p> <p>8 On 13 October Mr Slaymaker emailed Mr Schamberger. 9 He set out the actions that had been completed so far, 10 namely: CCTV; statements taken; enquiries about Daniel's 11 work, or some enquiries about that; Gabriel's property; 12 the toxicology target; and the phone work that had been 13 done so far.</p> <p>14 But, firstly, the backdated phone work was still not 15 done, backdated to 1 August, and there had been no 16 statement taken from Daniel's employer. They had the 17 statement from the colleague, you will remember, but 18 they didn't have one from his employer.</p> <p>19 Mr Slaymaker agreed before you that that statement 20 should have been taken and the employer should have been 21 asked whether Daniel was working on 27 and 28 August, 22 the days around Gabriel's death. For some reason 23 records are no longer available in relation to that, by 24 the time Lilford asked for them they were no longer 25 available.</p> <p style="text-align: center;">Page 7</p>
<p>1 remembered that that in fact is what had happened, 2 Daniel had come home with some cakes. That information 3 about the cakes came from Operation Lilford, right on in 4 September 2016, but it was available back in 2014, on 5 Ricky's phone, had that enquiry been made.</p> <p>6 Just going back to Gabriel's toxicology, you will 7 remember that the findings were that he had a very low 8 level of alcohol. He had some methylamphetamine, but 9 not enough to cause his death. His death was caused by 10 a very high dose of GHB, 758 micrograms per millilitre, 11 which is towards the top end of the range in which death 12 has occurred. The range is 27 to 1,030, so 758 was 13 towards the top of that range where death has occurred.</p> <p>14 In addition in Gabriel's case there was a very high 15 level of mephedrone, a drug which is used to stimulate 16 and induce euphoric effects, those two drugs together, 17 ingested in such large amounts, would be fatal, so said 18 Dr Soosay in her final report after the toxicology had 19 been referred to her and that was available, as you 20 know, from 7 October.</p> <p>21 On 10 October, DC Berry, who was not a witness you 22 heard from but he did some intelligence checks on 23 Gabriel on the system called IIP.</p> <p>24 On 11 October, once DC Baxter finally found out that 25 there was already a statement from John Pape which had</p> <p style="text-align: center;">Page 6</p>	<p>1 I have reminded you already that Ricky's statement 2 made it clear that it was very unlikely that Daniel had 3 anything to do with Gabriel's death and Mr Schamberger 4 agreed that should have been flagged up, but it wasn't 5 and it was overlooked.</p> <p>6 You can see from the chronology what was done on 14 7 and 16 October in relation to checks. But then DC Berry 8 signs off the work as having been completed, when the 9 phone work had not in fact been done.</p> <p>10 On 17 October Dr Soosay produced her post mortem 11 report and I have told you what her conclusions were.</p> <p>12 Meanwhile, in the Anthony Walgate investigation, on 13 18 October, as I told you yesterday, Mr O'Donnell was 14 sending Mr McCarthy an update with a view to submission 15 to HAT, but that never happened. Instead Mr O'Donnell 16 asked Mr Parish to do a report for the CPS, and we dealt 17 with that yesterday.</p> <p>18 Back to this investigation, on 20 October 19 Mr Schamberger updates the CRIS, but there is no 20 reference to the phone work. He accepted that that 21 work, that phone work, had fallen off the radar by then.</p> <p>22 Instead, on 4 November, Mr Schamberger signs off the 23 phone work as having been completed, when in fact 24 nothing had been obtained. He agreed when it was put to 25 him that this was an incredibly inefficient way of</p> <p style="text-align: center;">Page 8</p>

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<p>1 working and by signing it off, the phone work was never 2 in fact therefore to be done.</p> <p>3 On 17 November Ms Stanworth, the toxicologist, 4 reported on Daniel. The finding that in his case too -- 5 this is now the third time -- there was a high 6 concentration of GHB in his system. Her report is dated 7 21 November, but, as you will remember, despite it being 8 available to the police from them, it wasn't sent to 9 Dr Swift and he had to chase it several times.</p> <p>10 We then come to two important emails from John Pape 11 to DC Baxter.</p> <p>12 The first of them on 7 December, I wonder if that 13 could be put up on the screen, please, it is our -- 14 thank you.</p> <p>15 If you look at the bottom one first, this is 16 John Pape to Jacqueline Baxter, raising his concerns, 17 including the information about:</p> <p>18 "... older men drugging younger men in order to take 19 advantage of them sexually.</p> <p>20 "I worry about what is happening to young men in 21 Barking."</p> <p>22 You will remember that information came from the 23 communications between Mr Pape and Mr Amodio.</p> <p>24 DC Baxter didn't reply to that email, so Mr Pape 25 followed it up on the 11th. That is an email at the top</p> <p style="text-align: center;">Page 9</p>	<p>1 Instead, on 22 December 2014, the investigation was 2 closed by DC Berry.</p> <p>3 Then on 7 January it was closed by DS Turrell. 4 Then finally on 22 January, closed by Acting 5 Detective Inspector Schamberger.</p> <p>6 All those dates being before the pathologist report 7 was available, and Mr Schamberger agreed that it was 8 inappropriate, indeed wrong, for the investigation to 9 have been closed down before the post mortem report had 10 been received.</p> <p>11 Mr Schamberger asked about all of this, said he 12 wasn't aware of any of the concerns raised by 13 Thierry Amodio or by John Pape. He said he should have 14 seen the John Pape emails and a statement should have 15 been taken from him about the party and so on. He 16 agreed that a statement should have been taken from 17 Mr Amodio as well. It is agreed that Ms Turrell's 18 reasoning, which I reminded you about yesterday, that 19 Mr Amodio was in Spain, was not a reason for not taking 20 a statement from him. He agreed that what John Pape and 21 Mr Amodio had to say was of the first importance in 22 trying to get to the bottom of the case, but instead the 23 investigation was closed down.</p> <p>24 The next date is 23 December, which is when the 25 pathologist report in relation to Anthony Walgate became</p> <p style="text-align: center;">Page 11</p>
<p>1 of this page:</p> <p>2 "Let me be more blunt: I have heard that Gabriel and 3 the young guy who died in the same churchyard (Daniel?) 4 were present at the same gay chemsex party the weekend 5 before Gabriel died, I have had indirect information 6 about the party and this person described a scenario in 7 which older men drug younger men in order to take 8 advantage of them sexually. Four young men have died of 9 'unexplained' deaths in Barking between 21 June and 10 22 September, Gabriel being the second, it would be 11 great if I could talk to you ..."</p> <p>12 She didn't reply to that email either and she agreed 13 she should have put that information onto the system. 14 She said no link had been made with Mr Pape's 15 information and the note that had been found with 16 Daniel, which was as described another fundamental 17 failure with which she agreed.</p> <p>18 No attempt was made by any officer to identify "the 19 guy I was with last night" or "the mate's place" both 20 referred to in the note, despite Mr Pape's concerns in 21 these emails. Both Mr Schamberger and other officers 22 agreed that that was potentially of very high 23 significance. As you will remember, in fact, 24 Karl Kamgdom, whose name the police had, could have 25 pinpointed Daniel to Port's flat and to Cooke Street.</p> <p style="text-align: center;">Page 10</p>	<p>1 available.</p> <p>2 I am feeding these in so you know where the cross 3 reference on dates is, in relation to the various 4 investigations. On your Anthony Walgate chronology you 5 have the events of late 2014 and early 2015, which you 6 can cross reference.</p> <p>7 On 13 January, Mr Schamberger prepared the closing 8 report for the coroner on Gabriel.</p> <p>9 On 8 April you will remember Mr Kirk was again 10 advising that Stephen Port's laptop should be 11 downloaded.</p> <p>12 Then, finally, Dr Swift prepared his report on 13 17 April in relation to Daniel, which included the 14 strong recommendation that the sheet should be 15 submitted, which he is clear he said to the officers at 16 the post mortem, but even after receiving that report 17 the sheet was not sent. You will remember, had it been 18 sent, it would have revealed Stephen Port's DNA on it.</p> <p>19 On 18 April, the coroner sent enquiries to 20 Mr Schamberger about CCTV, the handwriting and the 21 bedsheet and asking for closing reports. In that 22 context Mr Schamberger told you he hadn't read 23 Dr Swift's report. He hurriedly prepared the report on 24 Daniel, which is behind divider 60, and which you will 25 remember contained quite a lot of errors, such as</p> <p style="text-align: center;">Page 12</p>

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<p>1 reference to work having been done around the phone 2 number and various details which Mr Schamberger accepted 3 were misleading. He said had he read Ricky Waumsley's 4 statement, he would have seen that there was positive 5 evidence pointing away from Daniel being responsible for 6 Gabriel's death and he agreed that he had made 7 "a dreadful mistake".</p> <p>8 He agreed that he should not have interpreted the 9 toxicology and formed his own view as to the cause of 10 death. He should not have said that there were "no 11 suspicious marks", in the light of the bruising, and the 12 handwriting had not been confirmed, as his report said, 13 via diary and family.</p> <p>14 He agreed that there was no evidence as per his 15 conclusion of "both having had sexual encounters with 16 other gay men via websites and other parties have not 17 been identified".</p> <p>18 The sex swabs had not been submitted.</p> <p>19 In reality, as you know, Mr Pape and Mr Amodio had 20 identified other witnesses -- Karl Kamgdom, Tony Fairy, 21 Jon Luck and so on -- and Mr Schamberger agreed that 22 this report might or would have misled the coroner as to 23 what the true situation was.</p> <p>24 On 28 April the laptop was finally submitted. 25 On 19 June inquests were held into the deaths of</p> <p style="text-align: center;">Page 13</p>	<p>1 So no officer had linked Daniel and Gabriel's deaths 2 with the earlier death of Anthony, and even after the 3 inquest no one thought to send off the sheet, despite 4 the coroner's queries and despite the open verdicts. It 5 was agreed by the officers that anyone in the team could 6 have done that, sent off the sheet, but nobody did.</p> <p>7 In conclusion, in relation to these investigations, 8 Gabriel and Daniel, there were a significant number of 9 admitted failings and missed opportunities.</p> <p>10 Firstly, in relation to forensic evidence, I said 11 I would come back to this yesterday, Gabriel's 12 sunglasses could have been sent off, as could Daniel's 13 clothing, the neck swab, the sheet and the brown bottle. 14 When those matters were submitted by Operation Lilford, 15 they all came back with having Port's DNA on them.</p> <p>16 Secondly, had open source and social media enquiries 17 been done the falsity of the note would have been 18 exposed and Mr Amodio, Mr Kamgdom and Jon Luck would 19 have been identified or identifiable.</p> <p>20 Thirdly, phone data would have shown that Daniel was 21 not in Barking in August.</p> <p>22 Fourthly, a proper investigation into the 23 handwriting could have led to the true uncertainty and 24 an expert analysis, which as you will remember when it 25 was done in Operation Lilford came back within 24 hours</p> <p style="text-align: center;">Page 15</p>
<p>1 Gabriel and Daniel. It was at those inquests that the 2 family first learned that the bedsheet and the bottle 3 had not been tested, nor had they heard about the 4 bruising before.</p> <p>5 Mr Pape gave evidence at one of those inquests and 6 he referred the coroner to what he had heard about the 7 orgy and the reference to older men drugging younger men 8 and he expressed to the coroner surprise that there was 9 no contact between Gabriel and Daniel established by the 10 police. He also asked at the inquest whether there was 11 a link with Anthony but was told that there was none. 12 Mr Schamberger agreed that he did not have a grasp of 13 the evidence when he gave evidence at the inquest. He 14 didn't know that the phone data had not been obtained. 15 He told the coroner that there were no external parties 16 involved when, had the sheet been tested, it would have 17 shown that Stephen Port was involved.</p> <p>18 Following the inquest, the family said that they 19 felt that Mr Schamberger had let them down. Ricky felt 20 pushed out and Mr Schamberger agreed that Ricky should 21 have been dealt with as a next of kin. They all felt 22 that they had been ignored when they pointed out that 23 this was murder and that their information and enquiries 24 were not followed up. That included Mr Pape. 25 Mr Slaymaker apologised if they felt that.</p> <p style="text-align: center;">Page 14</p>	<p>1 showing that the handwriting was definitively that of 2 Stephen Port.</p> <p>3 Finally, John Pape's information about Gabriel's 4 movements and his concerns about the links between the 5 deaths should have been followed up both by DC Baxter 6 and other officers.</p> <p>7 Those matters were all put to Mr Schamberger and he 8 agreed that this was a significantly incompetent 9 investigation and said that the above criticisms put to 10 him by Ms Hill were fair. He agreed that if 11 an investigation develops on an early view, there is 12 a danger that the focus is on material which supports 13 that view, in other words confirmation bias. He agreed 14 that his team took the easy option of taking the note at 15 face value and that they failed to follow up lines of 16 enquiry which would have prevented Jack Taylor's murder.</p> <p>17 Mr Schamberger agreed that there was bad policing by 18 individual officers which occurred due to the range and 19 the extent of their other responsibilities.</p> <p>20 DI Kirk came back and gave some further evidence in 21 relation to these enquiries and he agreed the 22 investigation was disjointed, he agreed that the sheet 23 should have been tested, even as late as after the 24 inquests. He also agreed that had he conducted 25 a review, the deaths may have been linked and</p> <p style="text-align: center;">Page 16</p>

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<p>1 an opportunity for MIT to take over would have been 2 there and the similarities would have been looked at 3 much more carefully than they were on his watch. There 4 were unanswered questions and the investigations were 5 closed down too quickly. He said the local policing 6 model was not at that time fit for purpose. He, 7 Mr Kirk, did not know about John Pape's statement. 8 Then on 15 July Mr Parish got the USB back with the 9 detail of what was on Mr Port's computer and he prepared 10 the report, which he accepted did not reveal the true 11 picture as uncovered by DC Thomas and Operation Lilford. 12 Ms Mackay, in relation to these investigations, says 13 that she finds it surprising that the link between the 14 three deaths was not made for the following three 15 reasons. 16 Firstly, Mr Slaymaker was the family liaison officer 17 for both Anthony and Daniel and yet he saw no link or 18 similarities. 19 Secondly, the locations where the bodies were found 20 were so close together, they all died from GHB and none 21 of them came from Barking. 22 Thirdly, the reference to the press interview 23 involving Mr Kirk in which he asked for Anthony's 24 details makes it seem as if some sort of link had been 25 made back then in September, although Mr Kirk said he</p> <p style="text-align: center;">Page 17</p>	<p>1 a warehouse operative and champagne picker. He had 2 aspirations to join the security industry and had 3 recently taken a loan for training in that field. He 4 had had girlfriends, but Donna had had suspicions that 5 he might be gay or bisexual. His routine was to work 6 from Sundays to Thursdays. At the weekends he would see 7 his sisters and friends and was always home for Sunday 8 lunch. You know Stephen Port was in prison between 9 23 March and 4 June 2015, having been sentenced at 10 Snaresbrook Crown Court for perverting the course of 11 justice. 12 Mr Richards told you that the first contact that 13 Operation Lilford identified between Jack and 14 Stephen Port was in July 2015, but it was a very, very 15 brief conversation and it came to nothing -- 16 a conversation on Grindr. There was then no further 17 contact between Jack and Stephen Port until September. 18 On Saturday, 12 September Jack went to Donna's home 19 as usual. He then went for a curry with friends and 20 then on to the Trades Hall working men's club. He got 21 home at about 1.00 in the morning. He had had a few 22 drinks but was not drunk. He chatted with his dad for 23 a short while and then at about 1.10 told his dad he was 24 going to bed. 25 The Operation Lilford evidence showed that he went</p> <p style="text-align: center;">Page 19</p>
<p>1 didn't in fact see any link. 2 She said after the inquest Mr Schamberger should 3 have revisited the matter, bearing in mind the 4 unexpected open verdicts. 5 Between Daniel's death and that of Jack Taylor 6 Stephen Port attacked five more living victims and there 7 was one more, even after Jack's death. 8 Before I move to Jack, I remind you that it was 9 24 October 2015 that DC Parish identified Stephen Port 10 as being the male with Jack. 11 Then chapter 4, members of the jury, if you turn 12 over in your bundle to divider 12 you will see the 13 chronology relating to Jack. You will have noted from 14 the questionnaires that we went through yesterday that 15 there are no questions for you to answer in relation to 16 the investigation into Jack's death. As any failings 17 that there were, thankfully, did not contribute to any 18 further deaths. You have heard about the investigation 19 into Jack's death, as there are arguably some 20 similarities between the facts and the investigations 21 which may be relevant to your considerations of the 22 earlier investigations and those involved in them. 23 Jack was 25 when he was murdered. He lived at home 24 with his parents and was very close to his two sisters 25 Donna and Jenny. He worked in a bonded warehouse as</p> <p style="text-align: center;">Page 18</p>	<p>1 online when he went up to his bedroom, initially 2 searching for information about becoming a registered 3 security guard and how to get a security licence, but 4 then between 2.00 in the morning and 2.45 he was 5 communicating with Stephen Port and they agreed in the 6 end to meet at Barking station. Just before he left, as 7 you will see on the last entry on this first page of the 8 chronology, Jack set up Find My iPhone, before logging 9 off and heading for Barking. 10 He called a cab at 02.38, it picked him up at 2.43 11 and at 2.48 the taxi dropped Jack off at Barking 12 station. As you know, the CCTV then tracks them until 13 they go out of sight. It was that CCTV, which after 14 some clearer version of it had been obtained, that 15 DC Parish was to look at in due course but there are 16 further events to remind you of before we get there. 17 The CCTV showed Port and Jack meeting and walking in 18 the direction of Cooke Street from about 2.48 on the 19 Sunday morning, the 13th. There was then no more heard 20 of Jack, until his body was found 35 hours later. 21 At 12.50 or thereabouts in the afternoon of 22 14 September Mr Elmes, a groundskeeper in Barking, found 23 Jack's body. You have photographs of where he was found 24 and of course you have been there. It is the other side 25 of the wall from where Gabriel and Daniel were found the</p> <p style="text-align: center;">Page 20</p>

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<p>1 previous year. Mr Elmes flagged down two park officers, 2 PCs Holder and Taylor, and Inspector O'Donohue attended. 3 There were two searches of Jack, one done by the 4 officers without disturbing him and then one on the 5 inspector's direction down to skin. 6 They revealed no injuries, but those officers did 7 find a small brown bottle and a wrap of white powder. 8 You will recall they didn't find the tourniquet or the 9 wetwipes and they didn't notice the needle mark, but it 10 was, as you will remember, raining heavily so perhaps 11 that is understandable. 12 At 2.01 the CID arrived in the form of 13 Ms Adeyemo-Phillips and Detective Sergeant Sweetman. 14 They stayed for about 55 minutes in total. You will 15 remember Mr Sweetman had attended Gabriel's scene and 16 Ms Adeyemo-Phillips had attended Daniel's scene. 17 Mr Sweetman in fact mentioned that fact to his 18 colleague, that he had attended a crime scene at the 19 same location a year earlier in August 2014 and she says 20 she told him that she too had attended a crime scene of 21 a death on the other side of the wall. She told you she 22 had not in fact in the intervening period attended the 23 scenes of any other sudden deaths in the intervening 12 24 months, so no other sudden deaths since Daniel in her 25 case.</p> <p style="text-align: center;">Page 21</p>	<p>1 days. 2 Dr Soosay carried out the coronial post mortem on 3 Jack's body on 16 September. As with the three other 4 deaths, the cause of death could not be ascertained and 5 she sent off samples for toxicology. It was at the post 6 mortem that the tourniquet and antiseptic wipes were 7 found in Jack's clothing. Dr Soosay did note that 8 Jack's brain was swollen and his lungs heavy with blood 9 and water, which may be indicators, as you now are well 10 familiar with, of drug overdose. She also noticed what 11 she described as a possible needle mark on the inner 12 right elbow. You will remember that Jack was right 13 handed and the query was raised therefore as to whether 14 he could have injected himself in his right elbow or 15 would have done. 16 The bottle and the powder that were found with Jack 17 were sent off for toxicology. 18 After that 10-day delay, and the distress that that 19 had caused the family, Donna Taylor told you that she 20 called the number on the card that had been left, 21 Ben Tanner's number, and she said it was PC Jon Taylor, 22 so one of the two park officers, who called her back and 23 was apologetic that no one had been in touch. You will 24 remember you have Donna's notes about what happened and 25 they are behind divider 18 in your bundle, an example of</p> <p style="text-align: center;">Page 23</p>
<p>1 She says that she tasked PC Merritt, another of the 2 uniformed officers, to check behind the wall where the 3 body was found in case other property or more 4 particularly Jack's phone had been discarded and she 5 said she did that because she recalled that no phones 6 had been found on those whose bodies were found in the 7 churchyard in 2014 -- that's Gabriel and Daniel, 8 obviously. In a statement that she made in 9 November 2015 she stated that she had told Detective 10 Sergeant Sweetman that, in other words that there had 11 been no phones, and that she had made a connection 12 between the three deaths due to the location and the 13 lack of phones. Mr Sweetman doesn't recall that 14 conversation with Ms Adeyemo-Phillips. 15 At about 5.00 at that afternoon a young female 16 officer called PC Greenaway and two others went to 17 Jack's home and PC Greenaway just simply announced that 18 he was dead. His parents were naturally devastated. 19 Drugs were mentioned and straight away Mr Taylor said 20 Jack didn't do drugs. Police officers went to Jack's 21 bedroom and noted how tidy it was. They took away some 22 of his prescribed medication and left after about half 23 an hour, leaving a card with Sergeant Ben Tanner's 24 number on it and saying that he, Mr Tanner, would be in 25 touch. In fact the Taylor family heard nothing for 10</p> <p style="text-align: center;">Page 22</p>	<p>1 them is on your screen now. 2 The same day the two parks officers, Jon Taylor and 3 Dean Holder, visited the family. They commented to the 4 family how smartly dressed Jack had been and that he 5 didn't look like someone who was on drugs. However, as 6 the family interpreted it, the police were convinced 7 that Jack had died from a voluntary overdose and the 8 family felt that they gave up on Jack because of that 9 assumption, that he was a drug taker. Donna was adamant 10 that those two officers did tell them about the red 11 blanket, but none of the police officers recalls the red 12 blanket. You can see it in the photograph that you 13 have. None of the officers recall that. 14 When she was told or when they were told that Jack's 15 wallet was found in his left back pocket, Donna pointed 16 out that that was the wrong pocket, because Jack was 17 right handed. To summarise, you know she gave the 18 police a lot of information, having spent hours with her 19 sister Jenny on the internet researching all these 20 matters and you have her notes in which she and Jenny 21 piece things together, found the press reports into the 22 three deaths and worked out the similarities between the 23 deaths, for example on page 4 of her notes, which is on 24 your screen at the moment, all had GHB, no phones for 25 example, around the same area and all those matters that</p> <p style="text-align: center;">Page 24</p>

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<p>1 she has listed there, following the investigations that 2 she and her sister Jenny did. 3 The family were all adamant, as I say, that Jack 4 would not take drugs. 5 Donna also did some research on the little bottle 6 that was found and found out from her internet searches 7 that GHB was sometimes stored in eyedrop bottles or 8 hotel shampoo bottles and she also found out that it was 9 a date rape drug. 10 On 25 September, so we are now on page 4 of your 11 chronology, DI Kirk was informed by his junior officers 12 that the Taylor family felt let down, no doubt because 13 of that 10- or 11-day delay when they had heard nothing. 14 He agreed to you that one part of his organisation was 15 at that stage not doing its job. He didn't know that 16 Mr Tanner had never even met the family, despite his 17 details being the contact that were left on the day of 18 Jack's death. 19 On 28 September the sisters were taken to the scene 20 by those two parks officers, Jon Taylor and Dean Holder, 21 here in the Abbey grounds. Donna is convinced that they 22 were led to believe -- and the CCTV had shown -- that 23 Jack had walked alone into a park area, which of course 24 is not correct. You will see there were a number of 25 queries raised by her about that, but that is not what</p> <p style="text-align: center;">Page 25</p>	<p>1 You have on the screen Ms McDonald's notes as to what 2 Donna was saying that day. Donna had mentioned the 3 Abbey ruins on her investigations had thrown up that 4 they were a gay cottaging site and that she was "already 5 asking whether the previous deaths could have been 6 connected to Jack", but Lindsey McDonald told her there 7 was no reason to believe that they are connected. 8 The families say that they discussed the other 9 deaths with Mr Laffan. Donna Taylor had copied out the 10 press articles, and you will see those in her notes, and 11 she says she gave them to Mr Laffan but he has no 12 recollection of that and he thinks that during these 13 discussions when Donna was drawing police attention to 14 possible links he was upstairs in Jack's room, because 15 the search of the room took him some time. 16 Donna says she was saying Jack would not have gone 17 anywhere dirty like the scene of where his body was 18 found, but Mr Laffan didn't recall her saying that when 19 he was around. 20 You will remember that there was a syringe found 21 with Jack's body which was unused and Mr Laffan said he 22 didn't know that, that it was an unused syringe. 23 Donna recalls the police saying the death was not 24 suspicious and her words were "they dismissed us and 25 said that they were not connected". They were told</p> <p style="text-align: center;">Page 27</p>
<p>1 the CCTV showed. 2 PC McDonald became involved, Lindsey McDonald, and 3 she made notes of her contacts with the family which you 4 have on your screen now. She records that the family 5 believed his death to be suspicious because Jack did not 6 do drugs. 7 On 4 October Sergeant Laffan, who had become 8 involved, and Inspector O'Donohue put together 9 a comprehensive briefing note ready for a meeting on 10 Monday the 5th, which you have seen here, and you will 11 remember this, additions made in red by Mr O'Donohue. 12 This was all prepared ready for a briefing on the Monday 13 morning, Monday the 5th, which was to take place with 14 Detective Sergeant Sweetman and DI McSheffrey, because 15 "there were too many unanswered questions". 16 That meeting took place on 5 October and the senior 17 officers were advised that the male who Jack met would 18 need to be identified, so in other words the male on the 19 CCTV would need to be identified before the HAT team 20 could be contacted. That was the advice that they were 21 given. 22 Later that day Mr Laffan and Lindsey McDonald 23 visited the family to show them the CCTV, to see if they 24 could identify the male. Mr Laffan conducted a search 25 of Jack's room and described it as impeccably laid out.</p> <p style="text-align: center;">Page 26</p>	<p>1 Daniel had committed suicide and Gabriel was homeless. 2 As I have told you, Sergeant Laffan had no 3 recollection of Donna mentioning the possible links with 4 the other boys and says if he had been aware of that, it 5 would have "gone to the top". If he had seen Donna's 6 notes relating to the similarities, the same applied. 7 He didn't recall any mention of GHB as a date rape drug. 8 He would have looked into all of this if he had known 9 about it, as he did with the other enquiries around 10 CCTV, Jack's wallet, the phone work and Jack's coat. 11 Pausing there, matters that are in Ms McDonald's 12 notes were not, it is said, known to Sergeant Laffan and 13 had he known he would have taken further action in 14 relation to those matters. 15 On 18 September Teresa Steadman, the coroner's 16 officer, raised the coroner's concerns about there being 17 similarities between the earlier deaths, and that is the 18 document that is on your screen at the moment. We now 19 have the Taylor family raising concerns about 20 similarities and the coroner and the coroner's officer. 21 Ms Mackay said to you that that really should have led 22 to an enquiry into the similarities and there was no 23 basis for the repeated assertion by the police officers 24 that there was no link. 25 Once the family found out that Jack had no phone</p> <p style="text-align: center;">Page 28</p>

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<p>1 with him when he was found and once they were shown the 2 CCTV, they became convinced that the male he was with 3 had done something to Jack. Ms McDonald noted on 4 9 October, having seen the CCTV, that Donna said "she 5 was starting to think that maybe he was meeting up with 6 this male for sexual reasons".</p> <p>7 Donna said Jack's phone, she told the police this, 8 Jack's phone was always on and he even carried 9 a separate charging case with him so that he never ran 10 out of battery. Donna feels that they gave the police 11 all the information to prove the links, and she feels 12 that her brother should still be here.</p> <p>13 Mr Kirk, in relation to the Taylor investigation, 14 said Lindsey McDonald should have told Mr Laffan about 15 the family's concerns and that more should have been 16 done and that, added to the coroner's concerns, it would 17 have made a difference. He said:</p> <p>18 "I should have been told. People were telling 19 officers that there might be a link and officers were 20 closing their minds."</p> <p>21 He agreed that the similarities were obvious and 22 that everyone should have sat down in a room and 23 discussed it. He didn't even know that there was 24 a specialist crime review group to whom he could have 25 gone.</p> <p style="text-align: center;">Page 29</p>	<p>1 put together.</p> <p>2 HAT officers arrived at 15.15 that afternoon, and 3 there was a two-hour meeting at which the borough 4 officers pointed out that the cases were riddled with 5 suspicious similar circumstances. Nevertheless the HAT 6 decision even at that stage was for the borough to keep 7 the investigation that night, as "we could not prove 8 murder". That was despite the concerns that were raised 9 by the borough officers, including concerns about 10 confidence and the gay community.</p> <p>11 The borough had prepared a full and comprehensive 12 briefing and Mr McSheffrey laid out the evidence 13 documenting the very obvious bases for linking the four 14 deaths and that they were likely to be homicides at the 15 hands of Stephen Port, but still SC&O1 didn't take 16 primacy that day. Mr Kirk's view was that primacy 17 should have been taken straight away, because his 18 borough did not have the resources or the capacity to do 19 what needed to be done. It was in fact 24 hours before 20 they did take it over.</p> <p>21 Finally, Mr Kirk gave evidence before you and in his 22 conclusion he concluded by saying that he accepted that 23 things had gone wrong and he remains of the view that 24 HAT, for whom he now works -- he is now on the murder 25 investigation teams -- should have taken over the first</p> <p style="text-align: center;">Page 31</p>
<p>1 On 7 October 2015 Mr Laffan received the preliminary 2 toxicology results in relation to Jack. Ms Mackay said 3 that that was another -- what she called a staging 4 point, at which the links should have been made. CID 5 should have got grip and governance and all four deaths 6 referred back to HAT at that point.</p> <p>7 On 8 October queries were raised about the 8 photograph of Jack and whether the position of his hand 9 indicated that he might have been holding his phone and 10 his phone taken from his hand.</p> <p>11 On the 9th Donna was shown clearer footage of the 12 CCTV, or stills from the footage, and that is when she 13 raised the question as to whether Jack may have been 14 meeting the male for sexual reasons.</p> <p>15 On 12 October the family approved the press release 16 and the press release took place on the 13th.</p> <p>17 On the same date, the tourniquet and the swabs were 18 submitted for fingerprint examination.</p> <p>19 14 October is the date that DC Parish identified 20 Stephen Port from the CCTV as he walked past 21 Lindsey McDonald's computer. It was, as Mr Kirk 22 described it, a goosebump moment. He, Mr Kirk, 23 immediately convened a meeting of all the officers who 24 had been involved in the four deaths. He called the HAT 25 car and he ensured that four comprehensive files were</p> <p style="text-align: center;">Page 30</p>	<p>1 investigation. He said he accepts the deaths were 2 unexplained and he said:</p> <p>3 "The whole investigation has been a salutary lesson 4 to me and is something I very much keep in mind in my 5 current role."</p> <p>6 He says he now always bears in mind the pressures on 7 the borough and this investigation changed a lot of 8 mindsets. Mr Kirk agreed that the approach of local 9 policing should have been better and could have led to 10 the earlier arrest of Stephen Port. These were 11 important borderline homicide cases, they should have 12 been reviewed. There were missed opportunities in the 13 failures to investigate Anthony Walgate's case properly, 14 to find out Gabriel Kovari's last movements and 15 Daniel Whitworth's whereabouts, and he agreed that the 16 family and friends of those who died had important 17 information and that the way they were dealt with was 18 not acceptable. He concluded by saying that he was 19 deeply sorry.</p> <p>20 After Jack's death, and before the arrest of 21 Stephen Port, Stephen Port drugged and raped another 22 young male, described as X9.</p> <p>23 Just taking the matter forward on the chronology, 24 you have the details there.</p> <p>25 On 18 October Stephen Port was charged with</p> <p style="text-align: center;">Page 32</p>

<p>1 administration of noxious substances and remanded in 2 custody. 3 On 27 October he was charged with murder. 4 In due course, as a result of Operation Lilford, 5 Port's DNA was found on the bottle and the tourniquet 6 which had been found with Jack's body. 7 That is the end of my summary of the facts, members 8 of the jury. 9 I am just going to deal finally with the evidence 10 that you heard from Deputy Assistant Commissioner Cundy. 11 He said: 12 "This has been my absolute priority to find out what 13 went wrong, how it could be fixed and how we can 14 improve." 15 He said: 16 "From the time of Stephen Port's trial the 17 Metropolitan Police Service has publicly accepted that 18 things went wrong with these investigations. It was 19 clear to me that there were a number of missed 20 opportunities, as well as wider impact. Professional 21 standards were not met." 22 He said: 23 "I am deeply sorry, personally and on behalf of the 24 Metropolitan Police, that we did not conduct these cases 25 to the standard which the families deserved. It is</p> <p style="text-align: center;">Page 33</p>	<p>1 advice from serious crime command, so that specialist 2 advice and involvement did not always occur when it 3 could or should have. 4 Fourthly, the awareness and understanding of the use 5 of GHB, chemsex and criminal activity has now been 6 looked into. 7 Finally, engagement and understanding and working 8 with members from the LGBT+ community. He said although 9 there were independent advisers in 2014, their advice 10 was not sought and they could have helped challenge the 11 belief that the deaths were not linked. 12 In relation to the first of those areas, he says the 13 force has now been divided into 12 more resilient basic 14 command units, with broader larger teams including 15 intelligence and more local coordination. There is now 16 a closer relationship between local policing and 17 specialist teams. There are now four specialist 18 geographical crime hubs across London and one of those 19 is in Barking. Primacy is now a softer-edged decision, 20 the new specialist crime command works more 21 collaboratively with the boroughs and more HAT cars are 22 available 24/7. There is now a specialist crime review 23 group. 24 There is improved intelligence and analytical 25 support with local intelligence teams and increased</p> <p style="text-align: center;">Page 35</p>
<p>1 a matter of personal disappointment to me." 2 He then set out five areas in which lessons have 3 been learned. 4 The first was in relation to the quality of the 5 initial death investigations and the professional 6 curiosity, or lack of professional curiosity, of the 7 investigators, including the individual and collective 8 actions. The approach of both local and specialist 9 investigators should have been better and could have led 10 to the earlier arrest of Stephen Port on suspicion of 11 murder. 12 Secondly, the leadership of the original 13 investigators, including the direction and support for 14 investigators. There should have been more effective 15 direction, leadership, support and resourcing -- could 16 have identified and pursued other investigative lines of 17 enquiry. The lack of clear investigative structures and 18 strategies did not lead to any review, despite concerns 19 being raised by the victims' families, partners, friends 20 and members of the LGBT community. 21 Thirdly, the interactions between the local policing 22 and the specialist crime investigators, the interaction 23 did not on occasions meet the Metropolitan Police's 24 expectations. Local officers did not have the 25 willingness or confidence to challenge the views and</p> <p style="text-align: center;">Page 34</p>	<p>1 awareness of the PND's capabilities. Following the 2 £2.2 billion reduction there was a reduction in police 3 and staff and an increased workload with reduced morale, 4 but he said in the Metropolitan Police Service we did 5 all we could to keep officer numbers high. One of the 6 core elements of policing has always been to manage risk 7 and prioritise. 8 Acting up and temporary roles were not as extensive 9 in Barking as they were elsewhere, but I can understand, 10 he said, the additional challenge where in a small 11 borough a number of officers are acting up. 12 In relation to these four deaths, they fell into 13 a category of sudden and unexplained. There must now in 14 such cases always be a CRIS equivalent set up and when 15 deciding whether a death is suspicious or not, the 16 direction is to think homicide. 17 Mr Cundy said that in these investigations there was 18 a lack of professional curiosity, for example in 19 relation to the note, the lack of phones being found and 20 on numerous occasions actions were set which were not 21 followed. He said it is very unusual for there to be 22 such a wide number of individual and collective errors 23 or failures, despite all the failures these tasks were 24 tasks within the skill set of the local officers he 25 said. A lot of things were not followed through which</p> <p style="text-align: center;">Page 36</p>

<p>1 would have identified Stephen Port earlier. It needed 2 clear leadership.</p> <p>3 He said here there was a group of officers who time 4 after time did not do their job. It was not about not 5 having the time, there was a need to identify and 6 understand the risk and prioritise the workload 7 accordingly and shuffle around resources.</p> <p>8 He was asked again about the number of officers who 9 were acting, trainee or temporary and whether it was 10 unusual and could or should have affected the 11 performance of the borough.</p> <p>12 He said, firstly, every police officer of whatever 13 rank is an investigator.</p> <p>14 Secondly, there are other boroughs with more 15 officers in such roles and it is a routine part of 16 career development, but of course it does mean if people 17 are acting up or in temporary roles, it means even more 18 importantly that there should be good leadership and 19 supervision.</p> <p>20 He said the training now given to officers should 21 ensure there is no repeat of this. He said it was 22 astonishing for him to hear some of the things which 23 were not done here and that actions were signed off when 24 they had not been completed and that the Anthony Walgate 25 and Daniel Whitworth investigations were closed down</p> <p style="text-align: center;">Page 37</p>	<p>1 have been a regular review process. He said:</p> <p>2 "We can now commission an independent review through 3 a specialist crime group."</p> <p>4 But you will remember Mr Kirk was asked about that 5 and said he didn't even know that that review group 6 existed. Mr Cundy in that context said there needs to 7 be more information made available so that officers do 8 know that that facility is available.</p> <p>9 He said the facts here called for an internal and 10 an external review and that even with the pressures of 11 work described here, there is still a way to carry out 12 effective supervision. There was a lack of robust 13 leadership and he said I struggle to understand how 14 investigations were closed down when they were.</p> <p>15 In relation to primacy, Mr Cundy said he thought 16 that primacy should have been taken in the 17 Daniel Whitworth and Gabriel Kovari cases. He said 18 Anthony's case is more nuanced but he noted that 19 DCI Jones had said he would have taken it if he had 20 known about the PND information and the incident at 21 Barking station.</p> <p>22 He said if primacy is not taken there is still a lot 23 more that could and should have been done to support the 24 borough.</p> <p>25 In relation to GHB, he said many of the officers</p> <p style="text-align: center;">Page 39</p>
<p>1 prematurely. He said the new CRIS system will prevent 2 that.</p> <p>3 In relation to computer downloads he says there is 4 now a more advanced and efficient system and most of 5 that can be done locally and quickly.</p> <p>6 In relation to the way the families were treated, he 7 said it was plain wrong that Anthony Walgate's father 8 was told that it was his brother who was dead, that 9 Ricky was told that Daniel had hanged himself and that 10 Jack Taylor's family were just told that Jack was dead 11 by an officer who just blurted it out as she arrived in 12 their house, without even asking them to sit down. He 13 said it was also wrong that Ricky was excluded.</p> <p>14 He said it is particularly important to listen to 15 what the families are saying and a family liaison 16 officer is the bridge between the family and the 17 investigators. In relation to leadership, he said 18 review is a very important part of leadership.</p> <p>19 Donna Taylor's notes were referred to and he said the 20 review here wasn't done by the police, it was done by 21 the families and when they tried to engage the police, 22 they were not listened to. The Metropolitan Police 23 Service simply should not have allowed these four deaths 24 to take place within 15 months, so close together, with 25 no officer reviewing or making the links. There should</p> <p style="text-align: center;">Page 38</p>	<p>1 didn't know what GHB was or that it was a date rape 2 drug, "... we have undertaken a huge amount to raise 3 awareness in that context. The investigators here knew 4 that GHB was involved but they did not show any 5 professional curiosity to find out about it".</p> <p>6 In relation to engagement with the LGBT+ community, 7 he said, "... there has been a significant increase in 8 engagement since 2015. It is to be noted that there was 9 no advice by MIT for the borough to contact the local 10 independent advisory group". He was then shown the 2007 11 review into a serial killer of gay men with important 12 geographical links, and he accepted there are 13 similarities in that case to this. He said there was 14 still a failure here to recognise common threads and 15 more focus on determining promiscuity and risk taking, 16 rather than interpreting the true position.</p> <p>17 He agreed there are echoes of that 2007 report here.</p> <p>18 Finally, he considered as a whole the approach of 19 local policing and specialist investigators should have 20 been better and could have led to the earlier arrest of 21 Stephen Port on suspicion of murder.</p> <p>22 Members of the jury, can I now take you, finally, 23 please, back to the legal directions which are behind 24 divider 1 in your white file. Could you go, please, to 25 paragraph 48 on page 8. Can I point out that there was</p> <p style="text-align: center;">Page 40</p>

10 (Pages 37 to 40)

<p>1 an original version of this in the version I gave you 2 yesterday which I have changed, but we have left the 3 original version in because I think one or two of you 4 might have made a note on it but you should now have 5 a new page 8, beginning with "Final directions" 6 paragraph 48, going on to a second sheet, page 9, and 7 paragraph 54. I can see some of you have it, but 8 I think some of you might be on the wrong one. 9 Madam, if you could just go back a page, you will 10 see a new version, I hope? There we are. 11 Does everybody have that? 12 Could you cross out, please, the original version 13 you received yesterday, cross out the final directions, 14 because I have slightly tweaked them. We are going to 15 be looking at the new version with a couple of lines at 16 the top of page 9. Thank you. 17 No mystery, it is just a little bit more detail in 18 this version. 19 Okay, everybody at paragraph 48? 20 Shortly you are going to be retiring to consider the 21 conclusions that you need to reach on the questionnaires 22 that I took you through yesterday. Your task, as you 23 know, is firstly to amend or approve the short 24 narratives in each of the four cases and to answer the 25 questions on the jury questionnaires, as well as</p> <p style="text-align: center;">Page 41</p>	<p>1 what happens until the next day -- of course you don't 2 stay here forever. 3 When you have completed your task though you should 4 inform the jury bailiff and hand him your completed 5 questionnaires, together with the records of inquest. 6 You will remember you only need one questionnaire and 7 one record of inquest for each of the four cases. 8 Please make sure that any of your additions are clearly 9 legible. I will then check the answers to the questions 10 on the jury questionnaires, make absolutely sure they 11 have complied with the directions I gave you, and with 12 your entries on the records of inquest, and they will 13 then all be typed up. 14 We will then pause until the following day or, if it 15 is a Friday, until the Monday, in order that the 16 families and friends of the deceased can come to court 17 to hear your conclusions. I just want you to bear that 18 in mind. So when you have reached your conclusions, 19 whatever time of day that is, we will pause until the 20 next day, you will appreciate Anthony's family are in 21 Hull, so it is going to take them some time to get here. 22 Shortly before we sit again, I will provide you, 23 your foreperson with typed copies of the questionnaires 24 and the records of inquest for you to check, check that 25 they comply with what you wanted to say, and you will</p> <p style="text-align: center;">Page 43</p>
<p>1 entering the details on the record of inquest. You 2 should attempt, if you can, to reach unanimous 3 conclusions by producing a narrative and answers on 4 which you are all agreed. If there comes a time when 5 any majority conclusions can be accepted, you will be 6 brought back into court and told that this is the case. 7 Until you hear that from me, unanimous conclusions, 8 please, on anything that you reach. 9 If you haven't already done so, could you please 10 elect a foreperson. This is really important. It needs 11 to be someone -- I know you all know each other very 12 well now, so you will not have any difficulty with 13 this -- in whom you all have trust and who themselves is 14 confident in their ability to chair and control your 15 discussions, to ensure that your approach to your task 16 is conducted efficiently and in a logical sequence and 17 to ensure that everyone has their say and that 18 politeness and good manners pertain at all times. Your 19 foreman, I have called it a foreman, of course it can be 20 a lady or a man, should also be prepared to speak on 21 your behalf when you return to court. 22 On that topic, I have no way of knowing how long 23 your deliberations are going to last. I just interpose, 24 there, at the end of each day you will be brought back 25 into court and I will give you some directions as to</p> <p style="text-align: center;">Page 42</p>	<p>1 then be brought back into court and your foreperson will 2 deliver your conclusions in response to the questions, 3 which I will read out verbatim from the questionnaires. 4 I hope that is clear, that is how it is going to work. 5 I will read out the questions from the questionnaires 6 and your foreperson will read out your answers to them. 7 There we are, members of the jury. 8 In a moment I will ask the jury bailiffs to take 9 their oaths. They will explain to you the position so 10 far as breaks are concerned, if they haven't already 11 done so, and when you retire please start your 12 discussions but don't start them quite as soon as you 13 get into your room, because we need to do the donkey 14 work of getting your files up there and my team will be 15 doing that. Whatever else you do when you get up there, 16 don't start discussing the evidence until you 11 are on 17 your own in there, all right. 18 Thank you very much. 19 I will ask the jury bailiffs to be sworn, please. 20 (The jury bailiffs were sworn) 21 THE CORONER: Right, members of the jury, if you would like 22 to go now with the ushers, please. 23 (The jury retired) 24 (10.32 am) 25 (The inquests adjourned)</p> <p style="text-align: center;">Page 44</p>

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