

INQUEST and INQUEST Lawyers' Group response to the Home Office's review of investigatory arrangements which follow police use of force and police driving incidents

17 November 2023

Introduction

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower Fire. INQUEST has published numerous reports and evidence submissions on the issues covered by this review over several decades.¹
2. The INQUEST Lawyers' Group (ILG) is a national network of several hundred lawyers who provide legal advice and representation to bereaved families – often acting pro bono where funding is unavailable – as well as promoting and developing knowledge and expertise in the law and practice of inquests.
3. INQUEST sits on the Ministerial Board on Deaths in Custody and its Executive Director, Deborah Coles, and a representative from the ILG sit on the advisory group to a Home Office review of the Independent Office of Police Conduct (IOPC).
4. INQUEST and the ILG's work has revealed a pattern of deaths which expose disturbing levels of neglect, violence and excessive use of force by police officers. Many of these cases involve Black people. Yet criminal and disciplinary action of the police is extremely rare. The institutional impunity afforded the police at an individual and corporate level indicates in most cases that police officers remain above the law and, it appears, un-sackable. This has caused bereaved families considerable, understandable anguish and frustration and has drawn attention from national and international scrutiny bodies, including from the Office of the United Nations High Commissioner for Human Rights and the European Committee for the Prevention of Torture.²

¹ See the INQUEST website for more information, <https://www.inquest.org.uk/justice>

² See the United Nation Working Group of Experts on People of African Descent, Visit to the United Kingdom of Great Britain and Northern Ireland, <https://www.ohchr.org/en/documents/country-reports/ahrc5467add1-visit-united-kingdom-great-britain-and-northern-ireland>, October 2023; United Nations High Commissioner for Human Rights, Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice and equality, <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G23/139/91/PDF/G2313991.pdf?OpenElement>, September 2023; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or

This review

5. The announcement of this review by the then Home Secretary Suella Braverman on the social media platform X (previously Twitter) linked to a news report on the decision to charge the officer who fatally shot Chris Kaba with murder and reports of Metropolitan police officers refusing to carry guns in response. Suella Braverman stated that firearms officers ‘mustn’t fear ending up in the dock for carrying out their duties’.³ The appropriate response to firearms officers from government would have been to remind them of their duties under criminal law and the application of the lawful use of force. Instead, this unnecessary and plainly political review was launched.
6. We note with concern the similarities between the Terms of Reference of this review – which the Home Office did not consult the public on – and Sir Mark Rowley’s September 2023 letter to the Home Secretary.⁴ Implicit in Sir Mark’s letter, we believe, is an assumption that independent scrutiny of the police, alongside the possibility of disciplinary action against officers following the use of force, is so commonplace it is hindering the ability to ‘let the police police’. INQUEST and the ILG’s considerable work with bereaved families shows this is not the case. While many bereaved families hope for some kind of accountability following the death of their relative – in the form of disciplinary action, prosecutions or a plain apology from the police – this is regrettably rare.
7. Sir Mark Rowley’s assertion, which it appears the Home Office have incorporated into this review’s Terms of Reference, that the deficiencies within the investigatory system lie in the practices of external agencies, such as the IOPC, is disingenuous: it is very often the police and their representatives who frustrate the investigatory and learning processes in ways which negatively impact bereaved families. The case of W80, which the Commissioner cites in his letter, is exemplary of this: while criticising the fact the misconduct process is still ongoing into W80 almost eight years after he fatally shot Jermaine Baker, the Commissioner makes no mention of the fact over four of those years were spent by W80 himself pursuing challenges in the courts. We note W80 was supported by the College of Policing and National Police Chiefs Council in some of these challenges.
8. It is also notable that this review has commenced less than a year after the publication of Baroness Casey’s review into the Metropolitan Police, which found the

Punishment, Report to the Government of the United Kingdom on the visit to the United Kingdom and the Isle of Man, <https://rm.coe.int/16806986e2>, March 2005, para.45, ‘The existence of effective mechanisms to tackle police misconduct is an important safeguard against ill-treatment of persons deprived of their liberty. In those cases where evidence of wrongdoing emerges, the imposition of appropriate disciplinary and/or criminal penalties can have a powerful dissuasive effect on police officers who might otherwise be minded to engage in ill-treatment.’

³ Sky News, <https://news.sky.com/story/armed-police-must-not-fear-ending-up-in-the-dock-says-home-secretary-suella-braverman-after-protest-12968864>, September 2023

⁴ Sir Mark Rowley QPM letter to Home Secretary, <https://news.met.police.uk/documents/commissioner-letter-to-home-secretary-14-september-2023-dot-pdf-434982>, September 2023

service lacks accountability and transparency.⁵ The landmark government commissioned 2017 Angiolini Review into deaths and serious incidents in police custody also highlighted the lack of accountability and learning following deaths.⁶

9. Rather than seeking to improve or strengthen the systems of accountability for bereaved families and the wider public, we see this review as marking a decisive step in the wrong direction. The review signals a desire to dilute the current framework which enables accountability of the police. This would further deplete public confidence in policing, which is at an unprecedented low particularly among Black and racialised groups.
10. INQUEST and the ILG, alongside over ten civil society organisations, wrote to the then Home Secretary Suella Braverman requesting more time to respond to this review. Given its wide scope, a three-week timeframe to respond obviates the ability for victims, bereaved families and concerned organisations to meaningfully engage with the proposals. It is extremely disappointing that this extension was not granted and has meant we have not been able to comment on each point in the Terms of Reference. Further, correspondence from the new Home Secretary James Cleverly reaffirms the government's concerns about police confidence in investigations, noting 'the risk of reduced firearms resilience in police forces across the country due to their lack of confidence in the investigatory system'. If the Home Office formulates any specific proposals, it should consult with INQUEST, the ILG and others about those proposals before they are finalised. The absence of specific proposals at this point means the current process does not amount to sufficient consultation.
11. In what follows we build on our casework with bereaved families following a police related death to highlight how limited the system for accountability already is. We also make clear our fundamental opposition to any proposals which seek to curtail, limit or undermine the processes which allow for independent scrutiny of the police and the investigation of their actions.
12. INQUEST and the ILG also support the Police Action Lawyers' Group response to this review.

The legal/regulatory framework on use of force and police driving

13. This review seeks to 'examine the legal framework which underpins police use of force and driving'. To do this, the review states it will consider, inter alia, whether 'the relevant legal tests concerning the use of force in self-defence should be clarified or changed in respect of police misconduct proceedings and inquests', and whether 'the

⁵ Baroness Casey Review, An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service, <https://www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/baroness-casey-review/update-march-2023/baroness-casey-review-march-2023a.pdf>, March 2023. See pg.13 on the Metropolitan Police Service's specialise firearms unit where 'some of the worst cultures, behaviours and practices have been found'.

⁶ Rt. Hon. Dame Elish Angiolini, Report of the Independent Review of Deaths and Serious Incidents in Police Custody, https://assets.publishing.service.gov.uk/media/5a821d1040f0b6230269ae98/Report_of_Angiolini_Review_ISBN_Accessible.pdf, January 2017. See pg.23 p.1.12.

INQUEST

criminal standard of proof for a finding of unlawful killing should be used for inquests and relevant inquiries'. INQUEST intervened on two Supreme Court cases which clarified the above areas of law. In short, no clarification or change is necessary in these areas of law following those rulings. Further, INQUEST and the ILG are extremely concerned by any proposals which seek to raise these legal thresholds. We believe this would amount to a severe curtailment of accountability for bereaved families.

14. The legal position on police use of force is clear, with the existing legal framework allowing for lawful force. Where force is used by agents of the state, and particularly where that force is lethal, it cannot be controversial that those officers' actions are robustly examined. The possibility of accounting for those actions has to be recognised as a central responsibility of policing.
15. The Supreme Court clarified in July this year what the legal test is concerning use of force during police misconduct processes.⁷ The Court found the civil law test on the use of force applies to police conduct decisions, rather than the higher threshold of the criminal law test.⁸ The most severe consequence of a misconduct proceeding is dismissal. The criminal standard will still apply to officers prosecuted in criminal courts, meaning officers will not face prosecution for an honest but mistaken belief. (However, prosecutions may still take place where a court finds that the force used was disproportionate.)
16. INQUEST, alongside the organisation Stopwatch, intervened in the above Supreme Court case (*R (on the application of Officer W80) (Appellant) v Director General of the Independent Office for Police Conduct and others (Respondents)*) because of the adverse consequences to public confidence in policing that would arise if the higher criminal threshold were applied in police misconduct hearings. As our joint submission with Stopwatch makes clear, there is no evidence that currently applying the civil test in misconduct hearings has had an adverse impact, whether on an officer's mindset when deciding whether to use force, or otherwise, and that this approach can be easily applied.
17. Conversely, we argued the consequences of applying the criminal test would mean a small but important class of cases (including allegations of the discriminatory use of force) may escape public scrutiny and accountability. This would adversely affect public confidence in the police, particularly in light of the disproportionate police use of force on Black and racialised people.⁹ For example, an officer may have an honest

⁷ UK Supreme Court, *R (on the application of Officer W80) (Appellant) v Director General of the Independent Office for Police Conduct and others (Respondents)*, <https://www.supremecourt.uk/cases/docs/uksc-2020-0208-judgment.pdf>, July 2023

⁸ The civil test is 'on the balance of probabilities' whereas the criminal test is 'beyond reasonable doubt'.

⁹ INQUEST's own data collection shows there has been 1,877 deaths in police custody or following police contact in England and Wales since 1990. Our data also evidences that Black people are dying disproportionately: the 2011 census showed Black people made up 3.3% of the population yet from 2011 to 2021 Black people accounted for 13% of all deaths in police custody or following police contact. See INQUEST, 'I can't breathe: Race, Death and British Policing', pg 42, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=edfc7c01-e7bb-4a17-9c33->

INQUEST

belief that a person poses a threat which is discriminatory, for example by being based on unconscious bias or racial stereotyping that views Black men as more dangerous than White men. In such a case, under the criminal test, the discrimination is not directly relevant and will normally be overlooked.

18. The Supreme Court's ruling rejected the argument that officers can rely on any mistake of fact in disciplinary proceedings for the unnecessary use of force, whether or not the mistake was objectively reasonable. This means that officers who use force based on a mistake of fact can rely on that fact *only if the mistake was a reasonable one to have made*. The ruling provides police forces and the IOPC with the confidence to bring more disciplinary cases following police use of force. Ensuring the police are publicly held to account in respect of allegations of the discriminatory use of force is of public importance while seeking to reconsider the current rules as clarified by the Supreme Court greatly undermines this principle.
19. INQUEST also intervened in the Supreme Court case of *Maughan (R (Maughan) v HM Senior Coroner for Oxfordshire)*, wherein the Court clarified that the standard of proof for all inquest conclusions, including suicide and unlawful killing, is the civil standard as opposed to the criminal standard.¹⁰
20. In intervening in this case, INQUEST argued there was no lawful or principled basis for stating the higher standard of proof was required. We argued that the higher standard would impede the ability of inquests to establish the full circumstances of what led to someone's death.¹¹ For example, the higher threshold at inquests could result in more open conclusions because a jury cannot decide on a conclusion. This could prevent failures coming to light and/or fail to meet the bereaved families' expectations. Further, the ability to determine whether or not lethal force was justified is necessary to meet the Article 2 duty. We also argued that the higher threshold could inhibit the identification of learning and the prevention of future deaths, which is another statutory purpose of inquests.¹²

[8628905460e6](#), February 2023. The Home Office's most recent statistics published 15 December 2022 for the year April 2021 to March 2022 found there were 608,164 recorded incidents in which a police officer used force. 14% of these incidents involved people perceived as Black (although Black people make up only 4.2% of England's population). This is at a rate 3.0 times higher than those perceived as being from a White ethnic group, while in the Metropolitan police force area the rate is 3.4 times higher. Those perceived as male, aged 18 to 34 and from a Black ethnic group accounted for 7% of all use of force incidents, compared with 0.5% of the overall population, and a rate of 145 use of force incidents per 1,000 population. The Home Office statistics also show 17% of incidents of less lethal weapons involved Black people whereas people perceived as being from a White ethnic group were involved in proportionally less. See Home Office, Police use of force statistics, England and Wales: April 2021 to March 2022, <https://www.gov.uk/government/statistics/police-use-of-force-statistics-england-and-wales-april-2021-to-march-2022/police-use-of-force-statistics-england-and-wales-april-2021-to-march-2022>, December 2022

¹⁰ UK Supreme Court, *R (Maughan) v HM Senior Coroner for Oxfordshire*, <https://www.supremecourt.uk/cases/docs/uksc-2019-0137-judgment.pdf>, November 2020

¹¹ See sections 5 and 10 of the Coroners and Justice Act 2009

¹² For example, the Harold Shipman case demonstrates that if unlawful killing by a doctor is not identified, that may leave the doctor free to kill again.

21. In their November 2020 judgement, the Supreme Court found that applying the criminal standard could lead to an under-recording of certain types of deaths and agreed this could mean lessons were not learnt. Further, they found there was no lawful basis for distinguishing the standard of proof for suicide as opposed to unlawful killing. This judgement was a step forward for state and corporate accountability by enabling inquests to more accurately set out by what means and in what circumstances someone died.
22. In considering the legal framework on police use of force and related investigations, it is important to also consider the government's Article 2 duties. Article 2 (the right to life) of the European Convention on Human Rights prohibits the state and public bodies (such as the police) from taking life apart from in very specific circumstances. It is settled law, both in Strasbourg and domestically at the highest level, that there is an implied investigative duty within Article 2. Where a person dies in circumstances where there is reason to believe that a state agent or a public body might have caused or contributed to the death or failed to take steps to prevent it in circumstances where the systemic or operational duties arise, there must be an independent official investigation into what happened. There is a risk that if the threshold for carrying out investigations is set too high the ability to effectively discharge the Article 2 duty may be impeded.

Investigations and post-incident processes

23. This review seeks to explore whether the system for investigating deaths and serious incidents following police contact is 'working effectively for the police and public.' The scope of this question is vast, and it has not been possible to adequately respond to it within the timeframe given. In addition, the Home Office have not made any detailed proposals on this area which would allow for meaningful engagement. INQUEST have provided extensive evidence on investigations into police related deaths previously to parliamentary select committees, the United Nations and the 2017 Angiolini review on investigations into police related deaths.¹³
24. It is worth noting that the 2017 Angiolini Review was set up in response to concerns about the restraint related deaths of two Black men and the mechanisms for holding police to account. As Dame Angiolini said: '[i]n both cases it was not just the shocking immediacy and circumstances of the deaths that the families had to contend with, but also the appalling levels of delay, obfuscations and institutional bunglers that followed'.¹⁴ The Angiolini Review examined the procedures and processes surrounding deaths and serious incidents in police custody and made significant evidenced-based recommendations across policing, the justice system and the

¹³ INQUEST, Police Action Lawyers Group and INQUEST Lawyers Group, Submission to the Home Affairs Select Committee inquiry into police conduct and complaints, <https://committees.parliament.uk/writtenevidence/13061/pdf/>, January 2021; INQUEST, evidence submission to the United National High Commissioner for Human Rights, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e98ae5e6-a33a-4257-94d2-7db6c656d653>, December 2020; INQUEST, summary of INQUEST response to the Independent Review of Deaths and Serious Incidents in Police Custody, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=c8647acd-0374-4ce3-94a8-fa1bb8516e34>, June 2016

¹⁴ Ibid, page 22, para 1.8

health service. It is the experience of INQUEST and the ILG that many of the issues that prompted the Angiolini Review are still relevant today and we would urge the government to consider her report during the course of this review.

25. Six years on from Angiolini's Review and bereaved families' testimony continues to reveal the significant challenges faced in trying to achieve investigations to ensure proper scrutiny of how their loved one died. For example, families report delays, denial and defensiveness during investigations, as well as misinformation and demonisation of their loved ones. This is often at great personal cost to families. Too often families' needs have been reduced to the lowest priority by those institutions more concerned to protect their interests than in learning and accountability.
26. We also question why the government is seeking views on whether the system is working effectively 'for the police'. As stated in the Police Reform Act 2002, one of the functions of the IOPC is to 'secure that public confidence is established and maintained'.¹⁵ The investigatory system is there to provide transparency and accountability of the police's actions for the public – it is not a system designed for the *police* but rather to independently scrutinise their actions. The fundamental requirements of the rule of law are that public servants should be dealt with before the courts on an equal footing with other citizens and their coercive powers should be constrained by precise legal rules.
27. Indeed, it is clear from our work with bereaved families that the current investigation and accountability processes work heavily in favour of the police. There is a historic and ongoing failure to adequately act on misconduct issues arising in police related deaths. In cases where gross misconduct proceedings have been brought against police officers following a death, charges are often not proven through this process, despite where there might be convincing evidence to the contrary. In rare cases where misconduct has been proven it has often been appealed by the officers. These failures are particularly evident in cases where the deceased was Black.¹⁶ In some of these cases the misconduct decision failed to reflect damning evidence heard at the inquest or critical conclusions about the shortcomings of the police. In other cases, the police sought to avoid and frustrate accountability through abuse of process arguments, judicial reviews and leaving the police force.
28. Cases of accountability through the criminal justice system following a police related death are vanishingly small. Since 1990, there have been 1,877 deaths in or following police custody or contact in England and Wales, as recorded by INQUEST. In that time, there has only been one successful prosecution of a police officer for manslaughter, and none for murder.¹⁷ There have been eleven other murder and manslaughter charges following deaths, ten of which did not result in successful

¹⁵ See Police Reform Act 2002, s.10 (1) (d)

¹⁶ See pages 16 and 17 of INQUEST's evidence submission to the United National High Commissioner for Human Rights, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e98ae5e6-a33a-4257-94d2-7db6c656d653>, December 2020

¹⁷ INQUEST, Dalian Atkinson: Police officer sentenced for manslaughter, <https://www.inquest.org.uk/dalian-atkinson-police-officer-sentenced>, June 2021

prosecutions and one of which is ongoing.¹⁸ Both successful and unsuccessful prosecutions have also been brought following deaths in police contact under Health and Safety legislation. Other criminal charges against officers, such as perjury and misconduct in public office, have been brought following deaths in custody, but most have led to acquittals or not guilty verdicts. We therefore reject the assertion that accountability processes are overwhelming the police from doing their job: the experience of bereaved families is that accountability has been minimal.

29. Many families have voiced their frustrations that the criminal justice system has failed to deliver accountability, particularly following deaths involving police use of force. INQUEST has long argued that families are not treated as ‘victims’ within the criminal justice system. There is often an unwillingness to investigate deaths on the basis that a potential crime may have been committed until proven otherwise. Police conduct which is potentially criminal is not subjected to the same rigorous investigative steps and processes as criminal offences committed by civilians. This leads to the long-standing perception that police officers are ‘above the law’ and protected by the system.¹⁹

“Officers are still keeping their jobs. They are not being suspended or their duties limited whilst the investigations are taking place. Families are not informed but most believe that it will be nothing more than a ‘slap on the wrist’. They also try to retire to avoid action. They know that they can get away with it.” Anonymous family quote

“There will be no change until the police are convicted of crimes, brought to account for gross misconduct, lose their jobs. In any other job that would happen. They need to know ‘if we don’t do our jobs properly, this is what’s going to happen’. Until they are brought to trial, I don’t think they will do.” Anonymous family quote

“The police need to be accountable, there needs to be a desire to change in the police and there is none. They’re not punished when they’ve done something wrong. [...] There is never a level playing field. How can you get justice in a system geared toward finding no one at fault?” Anonymous family quote

Timeliness of investigations and legal process

30. There are many stages where delays in the process of investigating deaths commonly occur, causing great frustration and pain to bereaved families as well as generating mistrust of the bodies involved in the investigation processes. While the terms of reference of this review focus on delays from investigating bodies such as the IOPC and Crown Prosecution Service (CPS), which INQUEST have previously provided evidence on,²⁰ less attention is paid to how the police themselves frustrate the investigatory process. Officers and their representatives have used delay as a means to justify abuse of process arguments and have successfully caused charges to be dismissed before hearings have had a chance to commence, meaning that officers are effectively acquitted without any evidence being heard. This is a complete

¹⁸ INQUEST, Chris Kaba: Met police shooter charged with murder, <https://www.inquest.org.uk/chris-kaba-cps-decision>, September 2023

¹⁹ As Dame Angiolini noted in her review, ‘There is a very strong perception that police sit above the law, and that a different set of rules apply to them.’ pg.169 para.13.2.

²⁰ Refer to footnote 13

denial of justice to people who are victims of police misconduct, in very serious and sensitive circumstances.

“The police seem able to object and appeal to [IOPC] recommendations and, since that all takes time, delays occur, and recommendations are not taken up.” Alison Orchard

31. The lack of cooperation and candour of police officers is one of the most contentious issues concerning deaths in police custody.²¹ While institutional defensiveness and a lack of candour are cultural problems within the police, its effects are felt by families during individual investigations into a death. The perceived reluctance to be interviewed or for the IOPC to interview under caution arises in the majority of cases. For most families, this goes to the heart of the issue of independence and why it is that police officers are treated differently to other citizens. It is common for IOPC investigations to face significant delays while officers under investigation are interviewed, only for the officers to give ‘no comment’ interviews, occasionally accompanied by a short-written statement.²² In the case of Leon Briggs, wherein the inquest did not open until seven years after his death, the police refused to present any evidence against their officers to the disciplinary panel.
32. Another hinderance to effective investigations into police related deaths involves the way in which police officers are able to confer with one another following a death. As outlined in the 2017 Angiolini Review, this impacts on the reliability and credibility of evidence from the police.²³
33. The impact on bereaved families’ and the public’s confidence in policing because of these police practices and the delays they cause is significant. It severely frustrates the learning and accountability processes. These excessive delays add an unacceptable burden on families, who without answers are unable to grieve properly and move forward with their lives. Where multiple bodies (such as coroners, the IOPC, CPS and Health Safety Executive) play a role in investigating deaths in police custody or following police contact, it is crucial that these bodies work together from the outset. This was a matter considered in depth in the Angiolini Review which recommended greater cooperation and agreed timelines between organisations involved from the very early stages and regularly throughout the course of any investigation.²⁴

²¹ The police’s institutional defensiveness has been raised repeatedly over several decades, for example in the Interim Taylor Report into the Hillsborough disaster, the 2017 review of deaths and serious incidents in police custody, by the chair of the statutory Anthony Grainger inquiry and more recently by the Daniel Morgan Independent Panel. As the Chief Inspector of the Constabulary and Fire and Rescue Services noted in 2021, there is a ‘culture of colleague protection’ in the police and a ‘circling of the wagons’ when they are faced with external criticism. See JUSTICE and INQUEST’s joint briefing on the Police Crime, Sentencing and Courts Bill, Amendment 71 – Accountability of public authorities: duties on police workforce, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=2652a013-001b-49ab-a1d5-6af7b8076589>, February 2022. We note the government’s recent announcement to introduce a duty of candour for police officers as per the Criminal Justice Bill 2023.

²² See also pg.12 para 45, INQUEST, evidence submission to the United National High Commissioner for Human Rights, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e98ae5e6-a33a-4257-94d2-7db6c656d653>, December 2020

²³ See the Angiolini Review, pages 142-3, para. 10.6 - 10.11.

²⁴ See the Angiolini Review, pages 10-11 para. 26-8.

34. However, it is important to remember IOPC, CPS, coronial or other processes do not duplicate work or subject officers to the same investigation multiple times. Rather, each process seeks to make use of the information made by another investigative body to address a different objective, all of which are necessary. There is scope for this to happen more efficiently, but the answer isn't changing the legal or procedural framework. In considering the timeliness of the investigatory process, it is crucial to ensure there is no weakening of current levels of independent scrutiny or accountability.

Post-incident communication and learning

35. This review seeks to consider what improvements could be made to officer and public safeguarding during investigations such as through anonymity orders. INQUEST's casework and monitoring points to a concerning number of cases where police officers have requested to remain anonymous at inquests and in misconduct hearings. Anonymity has typically been granted for police officers following fatal shootings, but increasingly we see anonymity being requested in other circumstances, such as where a death involved restraint. INQUEST is aware of at least six cases since 2017 where anonymity has been granted.

36. At the inquest into Rashan Charles, two officers and two witnesses were granted anonymity. At the inquest into Edson Da Costa, the police requested anonymity and ciphers for their officers, alleging among other grounds that they were at risk of reprisals as there had been Black Lives Matter protests following Edson's death. Police officers gave their evidence from behind a curtain and only the family members who were willing to give details of their name, address, date of birth and occupation, and to undergo a check against the Police National Computer, were allowed to see them.

37. Anonymity goes against the spirit of an open and transparent investigation and hinders scrutiny of public officials. In the case of *R (on the Application of Dyer) v HM Assistant Coroner for West Yorkshire (Western) Area CO/3140/2019*, the High Court ordered that seven family members be entitled to see 14 West Yorkshire police officers and a custody nurse give evidence at the inquest into the death of Andrew Hall, quashing the coroner's earlier ruling on anonymity. The ruling said the fundamental importance of open justice must be taken into account. The judge also noted the significant public interest in an inquest into the death of a Black man in (or shortly following) police custody. INQUEST gave a witness statement to the High Court, highlighting the benefit of bereaved families seeing key witnesses giving evidence at inquests, including enabling more trust in the investigation, having the opportunity to see and understand the body language of a witness, and seeing those involved in a death explaining their actions being held to account. The statement also highlighted the important role open and transparent investigations play in allowing public confidence in the process.²⁵

²⁵ INQUEST, High court quash coroner's anonymity ruling and allows family of Andrew Hall to see inquest evidence of police officers, <https://www.inquest.org.uk/high-court-quash-coroners-anonymity-ruling-and-allows-family-of-andrew-hall-to-see-inquest-evidence-of-police-officers>, November 2019

38. With regard to post-incident learning more generally, it is of great concern to INQUEST and ILG that over six years after the landmark Angiolini Review into police custody was published, the government have opened yet another review into many of the same issues. Given much of this extensive body of evidence from a government commissioned review still rings true, it is clear the government themselves are failing to implement their own learning.
39. Post-death processes should be a forum in which systemic failings can be identified, and from which essential changes can follow. However, INQUEST's work has highlighted how the possibility for prevention is undermined by the lack of a framework to monitor compliance with, and/or actions taken in response to, the findings and recommendations that emerge from post-death investigations. Every year we see countless preventable deaths occurring because of systemic failures to enact meaningful change.
40. Our concerns about excessive use of force were brought into sharp focus in the summer of 2017, where over a one-month period between 21 June to 22 July, there were four restraint related deaths of young Black men: Edson Da Costa, Darren Cumberbatch, Shane Bryant and Rashan Charles. We note the more recent deaths of Kevin Clarke and Oladeji Omishore, to name just a few.
41. Further, a review of coroners' Prevention of Future Death reports shows the recurrence of issues related to police use of force. This includes coroners' concerns regarding training on and awareness of the risk of death following prolonged restraint of someone suffering Acute Behavioural Disturbance (also referred to in reports as 'Excited Delirium'),²⁶ as well as concerns and recommendations over how individuals who have been subjected to restraint are monitored.²⁷
42. This is why we are calling on the Government to establish a National Oversight Mechanism, which would be an independent public body responsible for collating, analysing and following-up on recommendations arising from four post-death processes: investigations; inquests; public inquiries, and official reviews. We believe a National Oversight Mechanism would provide better learning, prevention, transparency and accountability for bereaved families following a state-related death.²⁸

²⁶ See the PFDs into Kingsley Burrell, <https://www.judiciary.uk/wp-content/uploads/2015/03/Burrell-2015-0472.pdf>, Darren Neville, <https://www.judiciary.uk/wp-content/uploads/2015/07/Neville-2015-0220.pdf>, and Terrence Smith, https://www.judiciary.uk/wp-content/uploads/2019/06/Terrence-Smith-2019-0095_Redacted.pdf

²⁷ See PFDs into the deaths of Duncan Tomlin, https://www.judiciary.uk/wp-content/uploads/2019/06/Duncan-TOMLIN-2019-0135_Redacted.pdf and Leon Briggs, https://www.judiciary.uk/wp-content/uploads/2021/10/Leon-Briggs-Prevention-of-future-deaths-report-2021-0330_Published.pdf

²⁸ For more information see INQUEST's briefing on the case for a National Oversight Mechanism, <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b480f898-7fbd-4c9c-a948-50dd3fad3a04>, June 2023

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“Unless the police become accountable, nothing will change, whether they follow recommendations or not. There has to be some means of enforcing change, they’ve got to follow the recommendations.” Anonymous family quote

Conclusion

43. As our response to this review makes clear, accountability for bereaved families following a police related death is extremely rare. Despite a plethora of recommendations on police use of force arising from investigations, inquests, inspectorate reports, inquiries and reviews, the same systemic failures are repeated. There is little evidence of institutional learning which has been extremely damaging to bereaved families’ and the public’s confidence in policing. This serves to frustrate the prevention of abuses of power, ill treatment, misconduct and future deaths.
44. Trust and confidence in the police is at an all-time low. A flurry of recent reviews have evidenced the shocking levels of racism, misogyny, homophobia and corruption within the police.²⁹ This should have promoted the government to take bold action to make positive changes in policing, however this review shows they are taking a contrary position.
45. We deplore the lack of political will to enact recommendations as well as the cynical and calculated attempts to dilute accountability mechanisms. We remind the government and the police of the fact independent scrutiny should not be seen as a threat. The system for holding the police to account for ill treatment and deaths of citizens in their custody is an indicator of our democracy and in the public interest.

²⁹ See for example the IOPC’s investigation into police strip search powers, <https://www.policeconduct.gov.uk/news/iopc-calls-review-police-strip-search-powers-following-child-q-investigation>, September 2023, and The Report of the Daniel Morgan Independent Panel, https://webarchive.nationalarchives.gov.uk/ukgwa/20220331103928/https://www.danielmorganpanel.independent.gov.uk/wp-content/uploads/2021/06/CCS0220047602-001_Daniel_Morgan_Inquiry_Web_Accessible.pdf, June 2021