RIGHTS OF LIFE AND DEATH: SHOOTINGS BY POLICE OFFICERS AND THE CORONER'S INQUISITORIAL PROCESS

by

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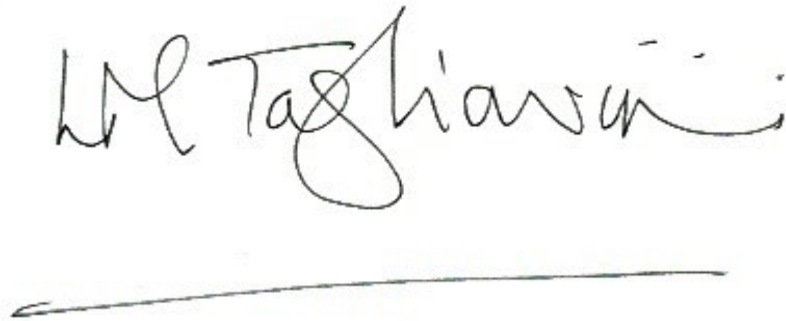
DECLARATION ____

I certify that this work has not been accepted in substance for any degree and is not concurrently submitted for any degree other than that of Doctor of Philosophy (Ph.D.) of the University of London. I also declare that this work is the result of my own investigations except where otherwise stated.



LM Tagliavini

ABSTRACT

This thesis examines to what extent the introduction of Article 2 of the European Convention of Human Rights, has contributed to a growth in adversariality at an inquest, where the death has occurred as a result of a police shooting. The inquisitorial 'no blame' forum of the coroner's court is used for investigating these deaths in England and Wales and it is these inquests that are among the most contentious. The engagement of Article 2 to inquests through the enactment of the Human Rights Act 1998, requires the coroner to include matters of police policy and planning as well as the procedures followed by the firearms officers in implementing the operation that led to the death.

The investigative limb of Article 2 embodied in the modernising legislation of the Coroners and Justice Act 2009, requires the coroner to ensures the bereaved are able to actively participate in all preparatory stages of the inquest of their family member which concludes with a final hearing. As a consequence, contentious deaths have become increasingly complex, lengthy and approached as an adversarial process rather than the coroner-led inquisitorial inquests that were held during the 1990's. Although an inquest determination of 'unlawful killing' can provide the bereaved with a public acknowledgment of their loss, it has also led to an increased expectation that a prosecution and conviction of a firearms officer will result. The determinations of 'lawful killing' reached by inquest juries indicate that the degree of accountability sought by the bereaved is not achieved through the inquest. However, the pursuit of a determination of 'unlawful killing' contributes to the undermining of the inquest's inquisitorial function.

This thesis examines the inquests that resulted from a police shootings between 1990 and 2018 and includes three distinct periods in the coronial service. This research shows that there is a correlation between the application of Article 2 to inquests and an increasingly adversarial approach from the opening of the inquest to the final hearing. At the same time, this adversariality does not appear to provide the bereaved with the expected outcome or degree of accountability sought, while it undermines the purpose of the inquest and calls into question its fitness for purpose.

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And to my family.

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ACPO	Association of Chief Police Officers
AFO	Authorised Firearms Officer
CAJ	Committee for Administrative Justice (NI)

CJA	Coroners and Justice Act 2009
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms commonly known as the European Convention on Human Rights
ECtHR	European Court of Human Rights
HRA	Human Rights Act 1998
NCITS	Northern Ireland Courts and Tribunal Service
IPCC	Independent Police Complaints Commission
IOPC	Independent Office for Police Conduct
MPS	Metropolitan Police Service
PCA	Police Complaints Authority
PFOA	Police Firearms Officers Association
RIPA	Regulation of Investigatory Powers Act 2000

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R (Bennett) v HM Coroner for Inner South London [2007] EWCA Civ 617, [1981] 2

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R (De Menezes) v HM Assistant Deputy Coroner for Inner South London [2008] EWHC 3356

R (Duggan) v Association of Chief Police Officer [2014] EWCA Civ 1635

R (Duggan) v HM Assistant Deputy Coroner for the Northern District of Greater

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R (Maughan) v HM Senior Coroner for Oxfordshire UKSC 2019/0137, [2019] EWCA Civ 809

R (Middleton) v Coroner for the Western District of Somerset [2004] UKHL 10, [2004] 2 AC 182, [2004] Inquest LR 17

R (Sharman) v Her Majesty's Coroner for Inner North London [2005] EWHC 857 (Admin)

R (Stanley) v HM Coroner for Inner North London [2003] EWHC 118 (Admin)

R (Thompson) v HM Coroner for South London (1982) 126 SJ 625

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TIMELINE OF SIGNIFICANT EVENTS

1174 Creation of the role of the coroner and the inquest forum

1836 Births and Deaths Registration Act was the first Act to attempt to record the number and nature of these events

1887 Coroners Act (a consolidating Act giving coroners powers of investigation)

1893 Parliamentary Select Committee set up to inquire into the sufficiency of the existing law as to the Disposal of the Dead, for securing an accurate Record of the Causes of Death in all cases, and especially for detecting them where Death may have been due to Poison, Violence or Criminal Neglect

1926 Coroners (Amendment) Act

1927 Registration (Births, Stillbirths, Deaths and Marriages) Consolidated Regulations

1936 The Wright Committee Report examines the process of death investigation ('the Wright Report')

1950 Convention on Rights and Fundamental Freedoms (known as the European Convention on Human Rights) is signed by the United Kingdom

1951 The ratification of the European Convention on Human Rights by the United Kingdom

1953 European Convention on Human Rights comes into force for the United Kingdom

1953 Coroners Rules

1959 Coroners Act (Northern Ireland)

1963 Coroners (Practice and Procedure) Rules (NI)

1971 The Brodrick Committee - set up to examine the systems of death certification and coroners ('the Brodrick Report')

1971 Criminal Law Act forbids the naming of the responsible individual inquest Verdicts

1984 The Coroners Rules

1988 Coroners Act

1996 Law Reform Act abolishing a 'year and a day' rule

1998 Setting up of Coroners Service Consultative Committee

1999 Access to Justice Act creates Legal Services Commission and provision for legal aid

1999 Coroners (Amendment) Rules

2000 Human Rights Act comes into force on 2nd October

2000 Announcement of government's intention to carry out a Fundamental review of coroner system in England, Wales and Northern Ireland

2003 Criminal Justice Act creates an exception to the 'double jeopardy' rule

2003 Death Certification and Investigation in England, Wales and Northern Ireland - The Report of a Fundamental Review ('the Luce Report')

2003 Third Report of the Shipman Inquiry: Death Certification and the investigation of Deaths by Coroners by Dame Janet Smith ('the Smith Report')

2005 Coroners (Amendment) (Northern Ireland) Act

2009 Coroners and Justice Act

2013 Coroners and Justice Act comes into force on 25th July with secondary Legislation

2013 Legal Aid and Coroners Courts Act (NI)

2017 Report of the independent review of deaths and serious incidents in police custody by Dame Elish Angiolini ('the Angiolini Report')

RIGHTS OF LIFE AND DEATH: SHOOTINGS BY POLICE OFFICERS AND THE CORONER'S INQUISITORIAL PROCESS

CHAPTER ONE: INTRODUCTION

1.0 Introduction

The purpose of the inquest has been described as:

> An inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.
>
> Lord Lane LCJ, *R v South London Coroner, ex parte Thompson*[1]

However, the inquisitorial nature of the inquest forum has not been met with unconditional acceptance from all users of the coroner's court. The role of the coroner and the purpose of the inquest as a means of providing justice and accountability to the bereaved, where other adversarial routes may be closed to them has been criticised by supporters of the interests of the bereaved.

> An inquest is not an adversarial court where you have an equal chance to challenge the authorised version of the facts. Instead it is the coroner who, aided by the police, is both judge and advocate, and controls the proceedings of his court. He alone has access to vital information stemming from an internal inquiry, but he is not obliged to divulge it. He alone decides which witnesses to call and in what order the evidence should be presented. He alone sums up and directs the jury, leads them and tells them to choose from a restricted range

[1] *R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625.

> of four verdicts, one of which is 'unlawful killing' and allows the relatives of the deceased a real chance to reopen the case with a view to prosecution and/or compensation. But such a direction to the jury is observed more in the breach.
>
> A. Sivanandan, *Deadly Silence: Black Deaths in Custody* [1]

This thesis is a study of the inquest forum in the context of deaths that have resulted from a police shooting in England and Wales. Numerous police shooting deaths have occurred in highly contentious circumstances and the reaction to some of these deaths having escalated into widespread public protests in the UK and a growth in international demonstrations against the use of fatal force at the hands of the state.[2] The focus of this research is the inquests that were held after a fatal police shooting in England and Wales during a period that saw substantive changes to the legal and procedural landscape of the coronial service. The timeline of this research includes inquests that were held under the old 1980's coronial legislation and those that were impacted by the implementation of the Human Rights Act 1998 and the application of its Article 2 'right to life'.[3] The timeline also includes inquests that resulted from a police shooting that were held in a period of modernisation of the coronial service in the form of the Coroners and Justice Act 2009.[4]

The thesis considers whether the application of Article 2 has caused or contributed to an erosion of the investigative nature of this inquisitorial forum and if so, the reasons for this and its effects on the inquest process. It also considers whether the use of the

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[1] A. Sivanandan, *Deadly Silence: Black Deaths in Custody* in *Deadly Silence: Black Deaths in Custody* (Institute of Race Relations 1991) 3.

[2] The shooting of Dorothy Groce in 1985 and the death of Mark Duggan in 2011 were two occasions on which social unrest followed a shooting by police firearms officers.
Gareth Parry, Susan Tirbutt and David Rose, 'Riots in Brixton after police shooting' (The Guardian 30 September 1985) <www.the guardian.com>the guardian>Sep>brixton-ri…> accessed 23 July 2020. See also David Waddington, 'The law of moments: understanding the flash point that ignited the riots' (cjm 87, March 2012) www.crimeandjustice.org.ukcjm>article>law-mom...> accessed 23 July 2020.

[3] Human Rights Act 1998, sch 1 incorporates the Articles of The European Convention on Human Rights (ECHR) (formally the Convention for the Protection of Human Rights and Fundamental Freedoms).

[4] Coroners and Justice Act 2009 received Royal Assent on 9 November 2009 and came into force on 25 July 2013.

criminally sounding outcome of an inquest in the form of 'unlawful killing' in this inquisitorial setting contributes to an adversarial inquest. This thesis examines whether any encroachment into the 'no blame' inquisitorial forum by the adoption of an

adversarial approach to the fact finding investigative forum of the inquest has brought with it any benefits for the bereaved or for other users of the coroner's court. This thesis investigates to what extent accountability is sought and achieved through the inquisitorial forum and whether it is sufficient to satisfy the bereaved and if not, whether in the absence of a criminal prosecution, the inquest for these police shooting deaths remains fit for purpose.

Although the existence of the coronial function is well known, the actual work of coroners, the system of appointment, their status and the process of an inquest is often less familiar. The purpose and limitations of the inquest forum often appear to be misunderstood by the bereaved and contributed to by the use of 'unlawful killing' as an inquest verdict or determination as despite its quasi-criminal terminology it is not an outcome that automatically equates to any or any successful criminal prosecution. Therefore, to understand how inquests into deaths at the hands of the state, and specifically those that have resulted from a fatal police shooting have changed both substantively and procedurally, it is necessary to lay out descriptive details which might otherwise not be expected and without which, the significance of the changes to the coronal service are at risk of being lost.

1.1 Deaths at the hands of the state

The sensitive and personal nature of the subject matter of the work of the coroner, the inquisitorial role of the inquest has tended to be less well written about than the adversarial jurisdictions of the criminal and civil courts. However, the widespread media coverage of contentious and high-profile shootings by armed police including those of Dorothy Groce, Jean Charles de Menezes and Mark Duggan has meant that their subsequent inquests have raised the public profile of the coroner and led to an increased awareness of the role of the inquest. This increased interest has translated

into several television broadcasts, which have included both documentaries and dramatised television programmes.[5]

Deaths that are classified as having occurred at the hands of the state or after state contact include those who have died as a result of a shooting by armed police officers; deaths which have occurred in a road traffic fatality after a police chase, deaths in or following police custody and other deaths following police contact that become subject to an investigation by the statutory independent investigative body.[6] Other deaths that are classified as having occurred at the hands of the state include those who have died in prisons, immigrations centres and in mental health units. The number of these deaths is considerable and the circumstances in which each death occurred are varied. Therefore, this research focuses on those deaths and their resulting inquests that have resulted from a shooting by police firearms officers and defines these for the purpose of this research as 'the contentious inquests'.[7]

1.2 Creation of the role of the coroner

Since the creation of the role of the coroner in the Twelfth Century there has continuously been in place in England and Wales a formal system in which certain deaths are investigated on behalf of the Crown.[8] Originally, used as a way of tax gathering, the early system of the inquest also provided a means of identifying criminal

[5] Some examples of this are seen in the BBC documentary Death Unexplained (2012) and the drama series Silent Witness and The Coroner.

[6] The third-party bodies responsible for independent investigations are; the Police Complaints Authority (1985 to 2004); the Independent Police Complaints Commission (2004 to 2018) and the Independent Office for Police Conduct (2018 to present day).

[7] According to the leading charity INQUEST whose figures on deaths that have occurred at the hands of the state are derived from its monitoring and casework and are independent of those produced by the Home Office and other official sources, there were 1740 deaths in police custody or following contact with the Police in England and Wales in the period 1990 to 2020. INQUEST defines police custody deaths as deaths that take place while the individual is in contact with police, whether or not they have been arrested, or that happen shortly after that contact and the death may not necessarily have occurred inside a police station. INQUEST excludes self-inflicted deaths following contact with police or deaths as a result of domestic violence where the police have been involved.
Statistics and monitoring: INQUEST www.inquest.org.uk>pages>categories>statistics-and-> accessed 10 May 2020.

[8] For a history of the coronial service, R.F Hunnisett, *The Mediaeval Coroner* (Cambridge University Press 2008). See also J Impey, *The Practice of the Office of the Coroner,* (5th edn. London 1822). [10] Coroners Act 1887, s 5.

accountability with coroners holding a power, which has long since been extinguished, to commit a named person suspected of criminal involvement in a death to the Assizes.[10] The limited role of the coroner and the purpose of the more modern day form of the inquest was described as being 'not the function of a coroner or his jury to

determine, or appear to determine, any question of criminal or civil liability, to apportion guilt or attribute blame.'[9]

Deaths due to state involvement are globally common although their treatment in the way they are investigated varies considerably. Some countries, which like the United Kingdom are a signatory to the European Convention on Human Rights (ECHR)[10] prefer to investigate these deaths through its criminal investigation processes rather than introduce a separate inquest forum.[11] Despite the longstanding expressions of dissatisfaction with the inquest forum found in official and independent reports and from users of coroner's courts, the inquisitorial coroner's inquest remains in England and Wales the preferred forum for investigating certain categories of deaths. These categories include those deaths where the deceased has died at the hands of the state.[12] The inquest forum has been retained in Northern Ireland and forms part of the Northern Ireland Courts and Tribunal Service (NICTS) and operates under its own specific legislation, while Scotland investigates certain deaths under the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.

[9] Master of the Rolls, Sir Thomas Bingham, LJ in *R (Jamieson) v HM Coroner for North Humberside and Scunthorpe* [1995] 1 QB 1, [1994] 3 WLR 82.

[10] Officially known as the Convention for the Protection of Human Rights and Fundamental Freedoms the Convention is more commonly referred to as the European Convention on Human Rights (ECHR). The United Kingdom became a signatory to the European convention on Human Rights in 1950 and ratified it in 1951.<www.echr.coe.int>Documents>Convention_ENG > accessed 12 May 2020.

[11] There is no single prescribed method for carrying out inquiries, but there is a requirement that they are effective; see *McCann v. UK* (1995) 21 EHRR 97 and appropriate publicity and involvement of the next of kin; *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51.

[12] Committee on Death Certification and Coroners 1965–71, *Report on Death Certification and Coroners* (HO 375, 1971) ('the Brodrick Report'). See also INQUEST, 'Briefing on Coronial Reform' (INQUEST, March 2011)<iap_deathsincustody.independent.gov.uk>2011/08>IN>accessed 12 May 2020.

1.3 The role of the inquest

The role of the inquest is to provide a fact-finding inquiry into a violent or unnatural death, an unexpected death, a death from an unknown cause or is a death, which has occurred in prison, state detention or after other contact with agents of the state.[13] Every inquest, regardless of the circumstances of the death must elicit answers to the four core questions of who died, when, where and how?[16] Although a death investigation is mandated by statute where deaths occur in certain circumstances, the

inquest may often be uncomplicated, requiring only written reports from those who can provide evidence on the four central questions. These may typically include the deceased's general practitioner, emergency services and hospital personnel. The uncomplicated type of inquest may be concluded on documentary evidence alone and without the need for witnesses to attend to give oral evidence if the next of kin gives consent or otherwise does not object to this course of action. Regardless of whether the coroner hears the evidence of oral witnesses, all inquests are required to be heard in public and are frequently determined by utilising a combination of both uncontroversial written evidence and oral witnesses.[14]

The inquest is not intended to answer questions concerning criminal or civil liability and the coroner has no powers of punishment or enforcement.[15] However, the bereaved may use the inquest to make a renewed and more persuasive request to the Crown Prosecution Service (CPS) for a reconsideration of its decision not to bring a criminal prosecution as well as providing a forum in which to gather evidence for a subsequent civil claim for damages.[16] The coroner is also provided with power to write a report to any person or body that might be in a position to implement measures that

[13] Coroners Act 1988, s 8 has been replaced by the Coroners and Justice Act 2009, s 1. [16] Coroners Act 1988, s 11 repealed by Coroners and Justice Act 2009, s 5.

[14] Uncontroversial written evidence is likely to include the statement identifying the deceased; a G.P. report and statement from ambulance personnel and police officers who have arrived after the deceased has been discovered in non-controversial circumstances, Coroners (Inquests) Rules 2013, r 23.

[15] Coroners Rules 1988, r 36; Coroners and Justice Act 2009, s 5(3).

[16] The Guardian, 'Mark Duggan shooting: family settle high court claim against Met' *(The Guardian,* 10 Oct 2019) <www.theguardian.com>iuk-news>oct>mark-duggan>accessed 12 May 2020. In 2019,the family of Mark Duggan reached a settlement for an undisclosed sum with the Metropolitan Police Service in its civil claim for damages.

are likely to prevent a repeat of similar circumstances from arising and another death from occurring.[17]

1.4 Coroners – a local approach

A distinctive feature of the coroner's service derives from its exclusion from the court legal system of England and Wales. Unlike the criminal and civil legal systems of England and Wales, the coroner's service has historically been and remains a local service. The significant regional variations regarding both physical and financial resources between the coroner's jurisdictions have been and remain an ongoing cause

for criticism and dissatisfaction.[21] Although coroners are independent judicial office holders, they are not recognised as judges and do not form part of the judiciary.[22] In some regions, the role of coroner would be 'handed down' within a solicitor's practice without open competition or express local authority approval.[23] Coroners have long held powers to require the production of documentary evidence[24] and to compel witnesses to attend to give oral evidence at the inquest[18] although the coroner's court is not a court of record nor are is its findings binding on any other court.[19]

Currently, a local authority is responsible for appointing the senior coroner in whose area they will serve with the approval of the Chief Coroner. The Lord Chancellor may remove a senior coroner from office with the agreement of the Lord Chief Justice.[20] Coroners are usually qualified solicitors and barristers although provision was made in the Coroners and Justice Act 2009 (CJA) for appointing suitably experienced legal

[17] Coroners Rules 1984, r 43; Coroners and Justice Act 2009, sch 5, para 5 and the Coroners (Investigation) Regulations 2013, regs 28 and 29.

[18] Where a witness is served with a summons to appear in the coroner's court but fails to do so, they may be fined up to a maximum of £1,000 by the coroner and the matter may be referred to the police and CPS in respect of a charge for summary offence, Coroners and Justice Act, sch 6 pt 2.

[19] In a memorandum to Parliament predating the implementation of the Coroners and Justice Act 2009, submitted by the Coroner's Society of England and Wales, the coroner's court was described as '[A]n inferior Court of Record. It is equivalent to the Magistrates Court if we were to try to fit it into the familiar civil and criminal structures. It has, therefore, evolved as a local court of summary justice; thereafter, any other similarity ends.' Memorandum submitted by Coroners Society of England and Wales (CTB 4) <publications.parliament.uk>memos>ucm0402> accessed 22 June 2020.

[20] Only the Lord Chief Justice and the Lord Chancellor have the power to remove coroners from their post usually after an investigation by the Judicial Conduct Investigations Office, Coroners and Justice Act 2009, sch 3 pt 4 para 13.

executives to act as coroners.[21] Previously, medical doctors were also appointed as coroners, but since the implementation of the CJA only those previously appointed are permitted to remain in post as a coroner.[22] Whether a full-time or part-time

[21] The number of Coroner's areas currently stands at eighty-eight with a view to reducing them to seventy-five. Mergers of Coroner Areas – Courts and Tribunal Judiciary. <www.judiciary.uk>officechief-coroner>mergers-of->accessed 12 May 2020.

In this thesis the terms jurisdictions, regions and areas are used interchangeably.

[22] Courts and Tribunals Judiciary: Coroners < www.judiciary.uk › the-justice-system › coroners> accessed 20 October 2020

[23] Home Department, *Third Report: Death Certification and the Investigation of Deaths by Coroners: The Shipman Inquiry* (Cm 5854, 2003) 149. Also known as 'the Smith Report' after Dame Janet Smith, DBE who chaired the inquiry.

[24] Coroners and Justice Act 2009, sch 5.

appointment, all coroners hold the same powers regarding all procedural and substantive decisions that they are called upon to make when performing their duties.

Until the creation of the role of the Chief Coroner by the CJA coroners worked on a local level with oversight provided only by the courts.[23] Despite the current requirement for all coroners, whether senior, area or assistant coroners to be legally qualified, High Court judges have frequently been appointed as assistant (deputy) coroners. These appointments have been for the sole purpose of hearing a particularly sensitive, legally complex inquest that may include evidence that can only be disclosed to a High Court judge, as a coroner is prevented from receiving some securitysensitive material (including intercept-related material) that provides evidence relevant to the inquest.

[21] Qualified legal executives may also now be appointed as a coroner as well as barristers and solicitors all with the five-year post qualification experience. Tribunals and Inquiries: Judicial Appointments and Discipline, The Judicial Appointments Order 2008 SI 2008/2995; Tribunals, Courts and Enforcement Act 2007 s 5(1).

[22] Previously, coroners had to either have a five year legal qualification or be a medical practitioner of at least five years' standing. Under the 2009 Act, all newly appointed coroners must be legally qualified although transitional arrangements apply to medical practitioners already in post when the changes came into effect, these also apply where a coroner area is subsequently merged with another area. However,

[23] Operational Selection Policy OSP6 Records created by and relating to Coroners 1970–2000, (The National Archive amended May 2007) para 3.5. <www.nationalarchives.gov.ukdocuments>osp6> accessed 18 May 2020.

During the period from 1970 to 2000 The Lord Chancellor had oversight of the conduct of coroners as judicial officers and had the power to remove a coroner from office for inability or misconduct. [31] The Investigatory Powers Act 2016, s 56; Regulation of Investigatory Powers Act 2000, s 18; Coroners and Justice Act, sch 10; Chief Coroner's Guidance No. 30 <www.judiciary.uk>coronersguidance> accessed 10 May 2020.

In some cases, the need to consider security-sensitive material will be obvious as it will go to the core of the investigation. Where the evidence is both central to the inquest and confidential, the inquest has been dealt with by the nomination of a judge to sit as the coroner at the very outset of the process. Where this occurs the Chief Coroner will request the Lord Chief Justice, in consultation with the Lord Chancellor to nominate a person who, at the time of the nomination is a judge of the High Court, a Circuit judge, or a person who has held office as a judge of the Court of Appeal or of the High Court (but no longer does so), is under the age of seventy-five and to whom this security-sensitive material can be disclosed as a nominated person.[31]

A further notable and often unwelcome feature of the local nature of the coroner's service has been the idiosyncratic approach to inquests that has often been adopted by coroners and illustrated in the approach taken to the preparation of the inquest for the

a person who became an assistant coroner by virtue of the transitional provisions and only holds a medical qualification cannot become a senior coroner for a merged area. Coroners and Justice Act 2009, sch 3 and sch 22, para 3; see also Chief Coroner's Guide to the Coroners and Justice Act 2009 < www.judiciary.uk>coroners-guidace> accessed 10 May 2020.

final hearing .[24] Coroners have a full-time staff of coroner's officers who are drawn from civilian police staff, are former police officers or local authority employees or a mixture of both, with the relevant local authority providing administrative staff to support the coroner.[25] In some areas, the local authority is responsible for employing coroner's officers if the coronial service has been transferred to it from the local police authority.[26] Under the 1980's legislation and the CJA a coroner's officer is the first point of contact when a death is reported to the coroner and who continues in this liaison role until the inquest is concluded. These officers work to the coroner's instructions on the legal and procedural steps required to prepare the inquest in

[24] In Chapter Five and Chapter Six details of this idiosyncratic approach to inquests is demonstrated in the inquest files to which access was provided by the senior coroner. In an effort to provide a more consistent approach there has been an implementation of mandatory national training for coroners and coroner's officers, as well as the appointment of a Chief Coroner whose Law Sheets and Guides are intended to provide a more uniform service to users of the coroners courts, albeit one that remains a local rather than a national one.

[25] The current trend is to have coroners' officers who are employed by the (lead) local authority in the coroner's region they work rather than the police force serving the area.

[26] Essex Coroners Service is an example of a previously police-funded service that has been transferred to the Local Authority <coroner.essex.gov.uk> accessed 17 May 2020. However, in West London the coroner's officers are funded by the police <www.lbhf.gov.uk › births-deaths-and-marriages › deaths > accessed 17 May 2020.

readiness for the final hearings as they have no powers to make any judicial decisions that are the sole responsibility of the coroner.[27]

1.5 Evidence gathering and the CPS

The civil and criminal courts of England and Wales have long had an adversarial system that can be divided into three phases comprising the investigative phase, the examining phase and the trial.[28] This system requires the participation of the parties and the presentation of the evidence they have gathered and where in the more serious of criminal trials, the judge acts as the decision maker on matters of law and the jury the decider of questions of fact.[29] Where an inquisitorial system is used in place of this adversarial model, the phases comprise the evidence collection and a decision on the prosecution, the examining stage of the evidence to assess its strengths and lastly the trial. Although inquisitorial, the inquest process mandates a hearing is to be held for a death that has occurred at the hands of the state and the inquest replaces a criminal

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trial with a hearing in which there are no parties and where there can be no expressions of blame or findings of guilt.

Once a death is reported to the coroner and an inquest is require a short hearing is held to open the inquest which is then adjourned pending further investigations and a decision by the CPS on a prosecution.[38] The inquest relies on evidence gathering by the coroner with the fact finding decision making as in criminal trials, left to a jury.[30] However, coroners do not tend to have the financial and administrative resources to independently conduct extensive evidence gathering and are therefore, reliant on others to compile the reports and witness statements that will provide the evidential basis of the final hearing.[31] The coroner may from time to time, either unprompted or

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[27] Coroners (Investigation) Rules 2013, r 7.

[28] Konrad Zweigert and Hein Kötz, (translated by Tony Weir) *Introduction to Comparative Law* (3rd rev. ed, Oxford University Press, 1998) 271.

[29] Gerald Upjohn, 'Evolution of the English Legal System' [1965] 51 ABA Journal 918, 921.

[30] Deaths, which have occurred at the hands of the state are required to be held with an inquest jury. In the majority of inquests, the coroner will sit alone and will be the decider of both matters of law and fact. Coroners Act 1988 s 8; Coroners and Justice Act 2009 s 7.

[31] In 2015, special investigators were appointed to take witness statements on behalf of the coroner for Northern Ireland in an attempt to move forward and bring to a final hearing, the more than fifty 'legacy'

at the request of an interested party or person, commission an independent report from an expert witness in a particular field of expertise.

In a contentious inquest coroners are heavily reliant on the reports provided from third party bodies. These have included the Police Conduct Authority (PCA)[32] and the Independent Police Complaints Commission, (IPCC).[33] Currently, the Independent Office for Police Conduct (IOPC)[34] is the statutorily created body that is required to carry out an investigation into a fatal shooting by armed police officers. Its report will usually be provided to the coroner for the purposes of the inquest albeit subject to redactions due to issues of confidentiality.[35] Since the application of Article 2 to UK

[38] Coroners Act s 16; Coroners and Justice Act 2009, s 11 and sch 1.

domestic law, these third party investigative bodies have been subject to the requirements of Article 2 regarding the nature and extent of its investigation into a fatal shooting by armed police officers. However, the independence and objectivity of the PCA and IPCC were the subject of sustained criticism particularly from groups representing the interests of the bereaved and led to their eventual replacement.[36]

Once a decision has been made by the CPS not to bring criminal proceedings against a firearms officer, the investigator's report is usually shared with the coroner.[37] This

inquests from 1970's and the period known as 'The Troubles'. However, no similar provision has been made for coroners in England and Wales.

[32] The Police Complaints Authority was formed in 1985 having been established by the Police and Criminal Evidence Act 1984 and its powers amended by the Police Act 1996 as an independent body with the power to investigate public complaints against the Police in England and Wales as well as related matters of public concern.

[33] The IPCC was created by the Police Reform Act 2002 and became operational in April 2004 when it replaced the Police Complaints Authority in an attempt to provide greater independence and objectivity to the investigations into complaints as to police conduct.

[34] As of 8 January 2018, the IPCC changed to the Independent Office for Police Conduct. Policing and Crime Act 2017, ch 5.

[35] The Independent Office for Police Conduct was created by the Policing and Crime Act 2017 in a renaming and reorganization of the IPPC and took over the role of investigating complaints against the police on 8th January 2018 and with the aim of instilling greater public confidence in the independence of its investigations including those into fatal shooting by armed officers.

[36] Ian Waters and Katie Brown, 'Police Complaints and the Complainants; Experience' (2000) 40 The British Journal of Criminology 617. See also, Tiggey May, Hamish Warburton and Ian Hearnden, Appellants', Complainants' and Police Officer' satisfaction with the Independent Police Complaints Commission, The Institute for Criminal Policy Research, School of Law, King's College London August 2008, www.nao.org.uk>uploads.2008/11.ipcc>accessed 13 May 2020.

[37] The provision of the (draft) report to the Coroner was the usual practice among the PCA, the IPCC and IOPC although subject to redactions regarding issues of confidentiality. [47] Bennetto, 'Police officer cleared of murder' *Independent* (15 October 1997)

report provides an account of the events leading up to the fatal shooting and will identify the relevant witnesses that the coroner may require to give oral evidence at the inquest, or whose written statement may be read out at the inquest. If a criminal trial has been held in relation to the death and irrespective of whether a defendant is acquitted or convicted, an inquest will not usually be resumed if the criminal proceedings have satisfied the state's investigative obligations.[47] Where the CPS decides not to prosecute any individual, the coroner can resume the previously adjourned preparation for the final hearing although may, at any stage of the re-refer the matter to the CPS in light of the evidence heard at the inquest.[38]

The role of the coroner in preparing for these inquests is the gathering of sufficient oral and documentary evidence from which the jury can answer the four core questions of fact of who died, when, where and how? However, the coroner's court cannot reach a different conclusion from that reached in a criminal court concerning the same events and the evidence given in the coroner's court cannot be used as of right in other court proceedings.[39]

1.6 The 1980's coroner's legislation

The Coroners Act 1988 and The Coroners Rules 1984 made no provision for the holding of pre-inquest review hearings or the mandatory disclosure of evidence to those recognised as having a legitimate interest in the outcome of the inquest and the interested parties designated as properly interested parties. Therefore, the coroner retained a wide discretion regarding all matters relating to the inquest. This included decisions on the ambit of the inquest, the witnesses to be called, the documentary

<www.indepedent.co.uk.new>police-officer-cleared> accessed 18 May 2020. See also, British Sussex County Police 'The killing of James Asley' (undated) <www.mojuk.org.ukPortia>ashley> accessed 18 May 2020.

Neither the inquest of David Ewin or James Ashley were resumed after the criminal proceedings were concluded as the coroner regarded that sufficient investigation had been carried out even though all officers were acquitted.

[38] The Coroners (Inquests) Rules 2013, pt 4 para 25. At the conclusion of the inquiry into the death of Azelle Rodney which found that he had been unlawfully killed by a firearms officer, the matter was referred to the CPS by the inquiry chairman Sir Tom Holland. Subsequently, a prosecution for murder was brought against Tony Long the firearms officer who had fired the fatal shot, a charge of which he was acquitted after a Crown Court trial.

[39] Civil Evidence Act 1985, s 6. This section makes provision for evidence used at an inquest to be introduced into other civil proceedings. [50] The Coroners Rules 1984, r 20.

evidence to be used, the grant or refusal of anonymity to witnesses and the date, time and place of the final hearing. In the absence of an appeal process, the coroner's decisions remained susceptible to judicial review.

The question of 'how' a person died was limited to an investigation of the immediate circumstances of the death regardless of whether it had occurred as a result of a police shooting. In the absence of preliminary hearings, the coroner would often without consultation with the interested parties, decide upon all matters pertaining to the management of the inquest, including issues of ambit, evidence and witnesses. At the hearing of the inquest, the coroner had the responsibility of questioning witnesses and actively eliciting explanations as to how the deceased came by their death. Although, questioning by the interested parties and members of the jury was permitted under the 1980's legislation, it was intended that the coroner would be chiefly responsible for the questioning of witnesses with only limited examination of witnesses by the interested parties, where it was considered to be relevant.[50]

Coroners routinely exercised their wide discretionary powers with limited recourse to the interested parties although the local nature of the service provided opportunities for variations between jurisdictions and the coroners in them. The disclosure of the evidence that was to be used at the inquest to the interested parties was not mandatorily required by the 1980's legislation and was often refused by the coroner. This refusal

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of the early disclosure of evidence was usually made on the grounds that statements taken by the police were in their possession and therefore not disclosable to the bereaved family unless voluntarily agreed by the police authority that the coroner could do so. Where there was no agreement by the police authority to disclose statements to the family, this had the effect of intensifying the imbalance between the police force concerned in the inquest and the bereaved.[40] The narrowness of the ambit of the pre Article 2 inquest, which considered only the immediate circumstances

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[40] *Peach v Commissioner of Police of the Metropolis* [1986] QB 1064; [1986] 2 WLR 1080; [1986] 2 All ER 129 1986

As the substantive evidence for the inquest was provided by the police force concerned, either directly or indirectly to the coroner, the coroner's refusal to provide disclosure of evidence disproportionately affected the bereaved. However, in 1999, the Home Office produced a voluntary code of disclosure under which police forces were encouraged to provide disclosure not less than 28 days before the date of the inquest proceedings. Home Office Circular 20/1999.

leading to the death left many of the bereaved families dissatisfied with the inquest process. Families would often be left without answers to questions that would allow them to better understand how their family member died, even if they did not accept the verdict reached by the jury.

The coroner's decision as to what verdicts to leave for consideration by the inquest jury emphasised the uniqueness of the inquest. Unlike the criminal courts where the choice of verdicts was known from the outset, the range of possible outcomes remained unknown to the interested parties and the jury until the coroner's summing up to them of the law and facts.[41] Of the short-form verdicts that could be left to the jury, the criminal standard of proof was required for a verdict of 'unlawful killing' with the civil standard applied to an 'open' verdict.

1.7 Inquests and Article 2 of the ECHR

Although ratified by the United Kingdom in 1951, the European Convention for the Protection of Human Rights and Fundamental Freedoms ('the Convention') only came into force on 3 September 1953.[42] The subsequent enactment of the Human Rights Act 1998 (HRA) on 2nd October 2000 brought the Articles of the Convention into effect in the domestic law of the United Kingdom and produced significant changes to

the way people sought to assert their human rights in the courts of England and Wales, including those in the coroner's court.

It had previously been in a decision of the House of Lords that the HRA did not cover inquests into alleged 'shoot to kill' deaths in Northern Ireland that occurred in the 1980's.[43] However, this position had to be retracted when the Grand Chamber of the European Court of Human Rights ruled the state's obligation to investigate suspicious deaths was 'detachable' from the substantive Article 2 duty to refrain from taking life.

[41] The Coroners Rules 1984, r 41; Coroners (Inquests) Rules 2013, r 33.
[42] Council of Europe, Treaty Office, <www.coe.int>Conventions>Full list>accessed 12 May 2020.
[43] *Re McKerr* [2004] UKHL 12)

Therefore, the procedural obligation to investigate could extend backwards and prior to the date when the ECHR came into force in a particular state.[44]

Article 2 provides 'everyone's right to life shall be protected by law' although this right is not absolute and in certain circumstances can be denied where proportionate and justified force is used.[45] Inquests where the death has occurred at the hands of the state and to which Article 2 automatically applies are often referred to as 'Article 2 inquests' thereby distinguishing them from those inquests in which Article 2 is not engaged. In *McCann v United Kingdom*[46] and *Jordan*[47] the European Court of Human Rights (ECtHR) held that where Article 2 was engaged, the ambit of the inquest became widened to include an investigation of the circumstances leading up to the death and not only the immediate circumstance coroners had previously considered. In the leading case of *Middleton* the House of Lords held that inquests into deaths where Article 2 was engaged required the coroner to look at the wider circumstances leading up to the death. The jury could then determine the answer to 'how' by including in their determinations of fact 'in what circumstances' had the deceased died.[48] As a consequence of broadening the ambit of the contentious inquests, they often included matters of police planning and policy as well as and the operating procedures of the police force concerned.[49]

Article 2 imposes both a substantive obligation on the state to protect life and a procedural obligation to provide an effective mechanism for investigating deaths that have occurred at the hands of the state and its agents.[50] It is the continued reliance on the inquest as the means by which, the state fulfils its investigative obligation in England and Wales that has brought with it a greater interest in the inquest and the

[44] *Silih v Slovenia* App no 71463/01 (ECHR 9 April 2009).
[45] See Appendix 1 for the full text of Article 2.
[46] *McCann v United Kingdom* (1995) 21 EHRR 97
[47] *Jordan v United Kingdom (*2003) 37 EHRR 2 [2004] 2 AC 182.
[48] *R(Middleton) v Coroner for the Western District of Somerset* [2004] UKHL 10. The court interpreted the question of 'how' the person died to mean 'and in what circumstances' thereby significantly broadening the scope of an Article 2 inquest.
[49] In the 2009 inquest into the death of Jean Charles de Menezes a central aspect of the inquest concerned the question of whether the metropolitan police service used a controversial 'shoot to kill' policy, after the deceased was fatally shot having been mistaken for a terrorist in the aftermath of the July 2005
[50] Guide on Article 2 of the European Convention on Human Rights. Right to Life. European Court on Human Rights (ECHR 31 C IV 31) Updated 30 April 2020.
<www.echr.coe.int>Documents>Guide_Art_2>ENG>accessed 12 May 2020.

outcome. The requirements of an Article 2 compliant inquest have demanded substantive changes to the practices and procedures previously adopted by coroners for the preparation and holding of these often highly contentious inquests. In order for an inquest to be compliant, it is required to be initiated by the state, independent, effective, open to public scrutiny, involve the next of kin to the extent necessary to safeguard their legitimate interests and to be conducted promptly and with reasonable expedition.[51]

Whereas the 1980's legislation had failed to expressly provide for the engagement of the bereaved in the inquest process, Article 2 required coroners to exercise their discretionary powers in such a manner as to ensure the inclusion of all interested parties particularly the bereaved, or otherwise be susceptible to a judicial review.[63] Until expressly provided for in the provisions of the CJA, coroners exercised their wide discretionary powers to hold preliminary hearings as a means to satisfy the requirements of Article 2. Where these hearings were held, all interested parties were entitled to attend and to contribute their views that were central to the transparency and effectiveness of the inquest.

A second significant change to the contentious inquests that Article 2 required was the pre-inquest disclosure of evidence by the coroner to all interested parties, including the bereaved. As the 1980s legislation had made no express provision for the provision of evidence, it was another matter left to the discretion of the presiding coroner and

bombings in London. However, it has been maintained by the College of Policing that such a policy has never been adopted. <www.app<.college.police.uk/app-content/armed-policing/use-of-forcefirearms-and-less-lethal-weapons/#reasonable-force>accessed 12 May 2020

was subject to widely differing local variations in approach.[52] The involvement of the bereaved required by Article 2 was interpreted to include the timely disclosure of documentary evidence. Although some material remained the property of the police force for whom the material was produced and the coroner had no power to order

[51] Guide on Article 2 of the European Convention on Human Rights: Right to life (ECHR 31 C IV 31) updated on 31 August 2020). Provides a detailed analysis of the state's obligations to investigate a stateinvolved death.
<www.echr.coe.int › Documents> Guide_Art_2>ENG >accessed 7 September 2020. [63]
R (Middleton) v Coroner for the Western District of Somerset [2004] UKHL 10.
[52] The case studies detailed in Chapter Five and Chapter 6 illustrate the variable approaches from coroner to coroner, whether in the same or different jurisdictions as each coroner, regardless of their seniority acted in the capacity of an independent judicial officer with the same decision-making powers.

disclosure of such material, it could be provided to the interested parties in accordance with the Guidance provided by the Home Office.[53]

As a result of these two significant changes brought about by Article 2 all interested parties including the bereaved, were provided with a proper opportunity to prepare for and participate in the final hearing, although families continued to experience significant difficulties in obtaining public legal funding and legal representation for the inquest under the exceptional funding provisions. This difficulty was due in part to official insistence that the inquest was a relatively informal inquisitorial process for which legal representation was unnecessary rather than an adversarial one.[54]

1.8 Inquests – a modernising approach

The coronial service has been the subject of numerous government committees and independent reports, which have resulted in recommendations intended to ensure the coroner's service remained fit for purpose in a modernising world.[55] Despite these numerous recommendations, there were repeated failures to implement them and the criticisms of the coronial service continued from official and independent sources. The local nature of the coronial service and the lack of uniformity among coroners in their interpretation and implementation of the legislation were a primary source of complaint. To the bereaved and interest groups the coronial service was perceived as

unfair and biased against the interests of the bereaved in its failure to make express provision for their inclusion in all steps of the inquest process.[56] The inquest forum was also regarded as providing an outdated service due to the legislation found in the

[53] Deaths in Police Custody: Guidance. Home Office Circular 31/2002.

[54] Legal Aid, Sentencing and Punishment of Offenders Act 2012, s 10. This Act introduced a provision for legal funding in exceptional cases with effect from April 2013. The Exceptional Case-Funding Scheme Guidance (Inquests) issued by the Lord Chancellor sets out the considerations a caseworker for the Legal Aid must consider when deciding whether there should be a grant of public legal funding for an inquest.

[55] 'The Luce Report' was published in June 2003 and reported on the corner service and the need for reform. Home Office, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003* (Cm 5831, 2003). This report was followed by the government position paper from the House of Commons Constitutional Affairs Committee, Reform of the coroner's system and death certification, (2006).

[56] Founded in 1981 the interest group INQUEST is the only charity providing expertise on state-related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. <www.inquest.org.uk> accessed 20 October 2020.

Coroners Act 1988, which was itself largely based on a consolidation of Acts related to births, marriages and deaths stemming from 1800's.[57]

One of the few substantial changes to the coroner's legislation that came into effect concerned the removal of the previously held power of the coroner to name in the inquest verdict, the person found to be responsible for the death being investigated.[58] The removal of this power was cemented in the Coroners Act 1988 and continued in the modernising legislation of the CJA and prohibits the inquest from deciding any issues of civil or criminal liability in any inquest verdict or conclusion.[59]

1.9 The Coroners and Justice Act 2009

In response to the continued calls for changes to the outdated 1980's legislation, consultation was held with a wide range of the users of the coroners court. In 2005, this consultation introduced a draft bill for the modernisation of the coronial service.[60] This Bill led to the Coroners and Justice Act 2009 although the enactment of this Act was delayed in respect of those parts affecting coroners and not brought into force until 25 July 2013 it expressly incorporated Article 2 into its provisions.[61] In response to objection by interest groups, the CJA excluded the 'secret' inquests proposed by the government to address the issue of security sensitive and confidential material which was likely to be required in the inquests arising from some fatal shootings by armed police officers. To the disappointment of groups representing the interests of the bereaved, the CJA also omitted the internal appeal process intended to replace the

current expensive and cumbersome judicial review process with an appeal made to the Chief Coroner, a role that was itself only reinstated after objections were made to its

[57] Coroners Act 1887; Coroners (Amendment) Act 1926.
[58] Criminal Law Act 1977, s 56. At the 1975 inquest into the fatal bludgeoning of Sandra Rivett, the nanny for the children of Lord Lucan named him as the person responsible for the death. Lord Lucan was the last person to be named in this way in an inquest.
[59] Coroners and Justice Act 2009, s 5.
[60] Department of Constitutional Affairs, *Coroner Reform: The Government's Draft Bill : Improving Death Investigation in England and Wales* (Cm 6849, 2006).
[61] Coroners and Justice Act 2009, s 5(2) provides 'Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998), the purpose mentioned in subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death'.

omission.[62] The CJA and the accompanying rules made significant changes to the inquest forum by ensuring the improvement of the service bereaved families receive and giving those who are suddenly or unexpectedly bereaved opportunities to participate in coroners' investigations which included rights to information.[63]

The CJA brought into effect changes to the adversarial sounding terminology previously used and replaced references to 'properly interested parties' with 'properly interested persons' and 'verdicts' with 'conclusions'. The reporting of deaths occurring in certain circumstances to the coroner remained unchanged, including the requirement to open an inquest where there had been a state related death and to hold it with a jury. However, the CJA has provided the coroner with powers to decide whether to open an investigation, rather than an inquest, pending receipt of an autopsy report and clarification of the cause of death before determining whether an inquest is required.[64]

As well as changes to terminology, the 2009 legislation has brought with it a number of other significant changes. One of the most important of these is the mandatory requirement for the coroner to provide pre-inquest disclosure of evidence to all interested persons, thereby removing the discretion a coroner had exercised previously with widely differing results.[65] The 2009 Act also makes provision for the holding of pre-inquest review hearings, the use of which has been actively encouraged by the Chief Coroner. These hearings allow all interested persons to play an active role in the preparation of the final inquest hearing and where issues relating to the ambit the inquest; the nature and extent of the evidence required; the grant or refusal of requests for anonymity by witnesses; the confidentiality of evidence; the use of independent expert evidence and the date and length of the inquest's final hearing are decided.[66]

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[62] Objections from interest groups and users of the coroner's courts included opposition to the scrapping of the role of the Chief Coroner from the Royal British Legion, which said the post was needed to improve the handling of inquiries into military deaths. BBC News, 'Chief Coroner: Royal British Legion welcomes U-turn (BBC news, 23 November 2011 < www.bbc.co.uknews>uk-politics15859410> accessed 20 December 2020.
[63] Coroners and Justice Act 2009, Background, para 14.
[64] Coroners and Justice Act 2009, s 4.
[65] The Coroners (Inquests) Rules 2013, pt 3 para 13.
[66] Chief Coroner. Guidance No.22 Pre-inquest Review Hearings.

These preliminary hearings, like the opening and final inquest hearings are required to be held in public and recorded.[67]

1.10 Public legal funding for inquests

The absence of an automatic grant of public legal funding to the bereaved for these contentious inquests has diluted the expressed aim of the CJA of putting the bereaved at the heart of the inquest. Originally the CJA had included a provision for legal funding for certain inquests, but this part was repealed before the implementation of this Act.[68] Although public legal funding for inquests remains available, it continues to be provided only under the exceptional provisions guidance. Legal funding remains subject to both a means and merits test, thereby ensuring that only in the most contentious of inquests are the bereaved publicly funded.[69] Consequently, bereaved families have been unable to secure legal representation at the inquest and have been reliant on the voluntary services of lawyers when unable to fund representation themselves. This is despite the longstanding and well supported campaign by INQUEST[70] that has been backed by the IOPC for the automatic grant of legal funding where the deceased has died at the hands of the state.[71]

In denying the grant of automatic public legal funding to the bereaved for an Article 2 inquest, the Ministry of Justice has consistently maintained that it considers an inquest to be an inquisitorial process. It considers that in most inquests, the state can discharge its obligation to hold an effective investigation without the family needing to be legally represented as it falls upon the coroner to ensure the inquisitorial inquest is ‘full, frank

[67] The Coroners (Inquests) Rules 2013, r 11(4) and 11(5). The coroner has the power to exclude the pubic from all or part of an inquest hearing if it is considered in the interests of national interest to do so and from preliminary hearings if in the interests of justice or national security to do so.

[68] Coroners and Justice Act 2009 s 51 initially brought advocacy at certain inquest within the legal aid scheme but this section was repealed by the Legal Aid, Sentencing and Punishment of Offenders Act 2012.

[69] Ministry of Justice, ‘Lord Chancellor’s Exceptional Funding Guidance (Inquests)’ (Updated April 2020) <assets.publishing.service.gov.uk>attachment_data>file> accessed 18 May 2020.

[70] INQUEST, ‘Now or never. Legal aid for inquests’ (26 February 2019) www.inquest.org.uk>legalaid-for-inquests> accessed 18 May 2020.

[71] ‘IOPC supports free legal representation for bereaved families in consultation response/ (IOPC, 31 August 2018) <www.policeconduct.gov.uknews>iopc-supports-free> accessed 18 May 2020.

and fearless'.[72] In considering whether legal representation is necessary, the Guidance on Exceptional Funding for Inquests requires a consideration of the individual facts

and circumstances of the death including the nature and seriousness of the allegations; the particular circumstances of the family; whether there have been any previous investigations into the death and if a significant wider public interest exists in the individual being legally represented.[73]

The definition of public interests can include the identification of dangerous practices, systematic failings or other findings that identify significant risks to the life, health or safety of other persons. However, it is not sufficient for there to be only a significant wider public interest in the inquest itself and requires a significant wider public interest in the family being represented. In addition, a financial eligibility test also applies although this criterion can be waived 'if, in all the circumstances, it would not be reasonable to expect the applicant to bear the full costs of legal assistance at the inquest'.[74]

Interest groups have stated that the absence of legal aid for the bereaved has been responsible for creating from the outset an 'inequality of arms' between the individual family member and the state body who is invariably legally represented at the inquest in addition to separate representation for individual firearms officers. This inequality of legal representation between the interested parties was a situation that initially appeared to have been remedied by the Coroners and Justice Act 2009, which made provision for legal funding for certain categories of inquests but which was subsequently omitted before the Act came into force and therefore remains the subject of an ongoing campaign.[87]

[72] *R (Jamieson) v HM Coroner for North Humberside and Scunthorpe* [1995] 1QB 1 [1994] 3 WLR 82
[73] Ministry of Justice, 'Lord Chancellor's Exceptional Funding Guidance (Inquests)' (Updated April 2020) <assets.publishing.service.gov.uk>attachment-data>file> accessed 18 May 2020.
[74] Ministry of Justice, 'Lord Chancellor's Exceptional Funding Guidance (Inquests)' (updated April 2020) p 36 <assets.publishing.service.gov.uk>attachment_data>file> accessed 18 May 2020.
[87] Coroners and Justice Act, s 51.

1.11 Article 6 – a right to a fair hearing

In accordance with the adversarial legal system of England and Wales there have long been procedures in place for a defendant's interests in a criminal trial to be safeguarded by the procedural requirements and evidential limitations placed upon the prosecution.[75] These rights are also expressly enshrined in Article 6 of the Convention, which affords a defendant the unqualified 'right to a fair hearing'.[76] Unlike the limited protections provided in the coroner's court, the rights of the defendant in criminal proceedings requires that certain safeguards are met. These include the provision of a clear statement of the alleged wrongdoing, the right to have presented relevant and admissible evidence and to call evidence in rebuttal as well as a right to make submissions on factual and legal matters to the court.[77]

In a civil case the rights of the parties are subject to the civil procedure rules where a failure to comply can lead to evidence being excluded or a case or part of it being 'struck out' with potential adverse implications for costs.[78] Although there is no requirement for a defendant to give evidence in his own defence, the process of the adversarial trial compels the active participation of both parties to present to a judge or a jury their own versions and accounts. In this process, the judge effectively acts as a referee to the competing stances adopted by the opposing parties with the jury in the role of the decider of facts.

As an inquest cannot determine civil rights or obligations or criminal liability, the absolute rights embodied in Article 6 of the Convention are not engaged.[79] As an

[75] Police and Criminal Evidence Act 1984. This Act includes major provisions that regulate the prosecutions of criminal offences.

[76] See Appendix 2 for the full text of Article 6 ECHR.

[77] Coroner's (Inquest) Rules 2013 r 22. This protection from self-incrimination that was also provided by the 1980's coroner's legislation, was widely used in the Stephen Lawrence inquest where those suspected as having an involvement in his death relied upon this "right," although they took the point even further by claiming "common law privilege" to every question asked no matter how mundane. See Wall of silence from white youths at Lawrence Inquest, Independent 12 Feb 1997 www.independent.co.uknews>wall-silence-from> accessed 13 May 2020.

[78] The Civil Procedure Rules. CPR 3.4

[79] Coroners Act 1988, s 11(6) and The Coroners Rules 1984 r 42. Coroners and Justice Act 2009, s 10.

inquisitorial forum the inquest also fundamentally differs from the proceedings in the criminal courts. In an inquest, the only protection afforded to an interested party or person, who is also a potential defendant in a criminal trial, is a warning that must be given by the coroner, of the right of the witness not to answer any specific question if the answer to that question may incriminate them.[80] It is the coroner's responsibility to be alert to this risk of self-incrimination and it is their duty falls to warn a witness

each time this risk arises. Although a witness can be compelled to attend an inquest, they cannot be compelled to answer certain questions although the refusal by police officers to answer certain questions serves to heighten a perception that they are hiding the truth rather than assisting the coroner to discover it.[94] As neither the criminal or civil rules of evidence apply to an inquest the evidence admitted in the inquest is required only to be relevant to its purpose with few limitations placed upon its admissibility.[81]

1.12 'Lawful' and 'unlawful killing' and accountability

Unlike a criminal trial where the range of verdicts is known from the outset and are mostly limited to guilty or not guilty, the possible range of inquest outcomes is unknown to any interested parties or person until the conclusion of the evidence[96] and the coroner's directions to the jury on the verdicts or conclusions it can reach.[82] The inquest provides an opportunity for a jury to reach the quasi-criminally sounding determination of 'unlawful killing' which is restricted to the criminal offences of murder, manslaughter (including corporate manslaughter) and infanticide. In reaching such a determination, the jury, until the recent decision of the Supreme Court in

[80] The Coroners Rules 1984, r 22. Coroners (Inquests) Rules 2013, r 22.
[81] For the defendant in a criminal trial, the right to far hearing includes knowing the charge made against them and the right to offer a defence and the right to challenge the admissibility of evidence. Police and Criminal Evidence Act 1984 (as amended). See also Civil Evidence Act 1995 (as amended). [96] The Coroners Rules 1984, r 40 and Coroners (Investigations) Regulations 2013 reg 27. These provisions prohibit interested parties or persons from addressing the coroner or the jury on the facts. In their submissions to the coroner made out of the presence of the jury, the interested parties/persons may address the coroner on the range of verdicts/conclusions the coroner may properly leave to the jury. However, to make sense of these submissions to the coroner, a reference to the evidence and facts is frequently required and is a practise endorsed by the higher courts.
[82] The Coroners Rules 1984, r 41 and Coroners (Investigations) Regulations 2013, reg 33. These both provide for the coroner's summing up to the jury and direction on the law, which includes only those verdicts or conclusions, which the jury can consider.

Maughan was required to apply the criminal standard of proof.[83] The jury is required to reach its decision based only on the evidence that has been admitted at the inquest and which may have otherwise been excluded at a criminal trial for reasons of hearsay, admissibility or relevance.[84] Inquest verdicts or conclusions need not be unanimous.

[94] Coroners and Justice Act 2009, sch 5 para 1, the coroner has the power to summons witness who face being found to be in contempt of court if they fail to attend. However, a witness cannot be compelled to answer questions to which the answers may incriminate them.

Juries have a minimum of seven and a maximum of eleven members and only a maximum of two jury members can disagree with the majority before the verdict or conclusion is unacceptable.[85]

Two of the short-form determinations sought in the contentious inquests are lawful and unlawful killing. A determination of lawful killing means that death resulted from the use of lawful force, which would otherwise amount to the crime of murder, manslaughter or infanticide but for the presence of a factor, which justifies the act on the balance of probabilities.[86] In a contentious inquest, the jury is asked to decide whether the force used by the firearms officer was justified. In answering this question, the jury must first consider whether the firearms officer honestly believed (even if mistaken) that it was necessary for to use force in defence of themselves or others and second, whether in the circumstances as they were believed to be, no more force was used than was reasonably necessary. For the jury to reach a determination of 'unlawful killing' the jury must be 'sure' that the firearms officer did not honestly believe that it was necessary to use force and the force used was unreasonable.[87]

[83] *R (on the application of Maughan) v Her Majesty's Senior Coroner for Oxfordshire* UKSC 2019/0137. The Supreme Court concluded that a conclusion of 'unlawful killing' was required to be determined 'on the balance of probabilities' rather than the criminal standard which had previously applied.

[84] The Chief Coroner's Law Sheet No.1 on Unlawful Killing sets out to what offences. i.e., murder, manslaughter (including corporate manslaughter) and infanticide this conclusion applies, and the standard of proof that is required on each element of the offences.

[85] Coroners Act 1988, s 12; Coroners and Justice Act 2009, s 9.

[86] Self-defence is a common law defence to offences of violence, while the defence of others is a defence recognised by section 3 of the Criminal Law Act 1967. Both defences are now governed by section 76 of the Criminal Justice and Immigration Act 2008.

[87] On 13th November 2020 the UK Supreme Court determined that the standard of proof to be applied for inquest conclusions of suicide and unlawful killing is the civil standard of on 'the balance of probabilities. *R(Maughan) v HM Senior Coroner for Oxfordshire* UKSC 2019/0137.

Despite any delay that is caused, inquests will not be held where the CPS is actively considering whether any criminal charges should be brought against any individual.[88] In deciding whether to bring any criminal charges, the Code for Crown Prosecutors requires, when viewed objectively, enough evidence to provide a 'realistic prospect of conviction.'[89] If no prosecution is forthcoming, the inquest that has been adjourned after its brief initial opening will proceed to a full hearing. As the adversarial process of the criminal courts takes precedence over the inquest, the determination of the inquest jury cannot differ from any verdict reached at a criminal trial. Therefore, there can be no verdict or conclusion of 'unlawful killing' in an inquest if there has already

<www.judiciary.uk › wp-content › uploads › 2016/02

been an acquittal of charges of murder or manslaughter.[90] However, with the abolishing of the 'double jeopardy' rule and the possibility of a second prosecution based on new evidence, the inquest at least in theory, remains an avenue for the uncovering of such new evidence on which the CPS can be asked to decide on whether a second prosecution is warranted. Consequently, during the final hearing, the coroner must remain alert to any potentially incriminating evidence and provide the appropriate warning to the witness.[91]

Although the coroner lacks the power to commit a person to the criminal courts, if it appears to that an offence has been committed, the matter can be referred to the Crown Prosecution Service at any stage, for its consideration whether any officer should be the subject of criminal charges.[107] Whatever the outcome of an inquest, the Crown

[88] Coroners Act 1988, s 16; Coroners and Justice Act 2009, Schedule 1.
[89] CPS, Code of Guidance, para 4.4
< https://www.cps.gov.uk/publication/code-crown-prosecutors> accessed 13 May 2020.
[90] In the 2016 inquest of Dorothy Groce all legal representatives for the police, the officers and the bereaved agreed that the jury could not consider a conclusion of 'unlawful killing' as the officer who had fired the shot rendering her paraplegic and that twenty-four years later was found to be a substantial cause of her death, had been acquitted in 1987 of assault charges thereby preventing any further prosecution on the same facts.
[91] When deciding on whether or not to prosecute the CPS Guidance states, 'Prosecutors should bear in mind the judgement in *R v DPP ex parte Manning* [2001] QB 330, which states that "where an inquest following a proper direction to the jury culminates in a verdict of unlawful killing ... the ordinary expectation would naturally be that a prosecution would follow." Where it happens no prosecution follows, the judgement directs solid grounds should exist to explain why this decision has been taken.'
[107] Agreement between The Crown Prosecution Service, The National Police Chiefs' Council, The Chief Coroner and The Coroners' Society of England and Wales (2016).
<www.cps.gov.uk>publication>agreement-between-cr…>accessed 13 May 2020.

Prosecution Service (CPS) may take it upon themselves to review the decision not to prosecute any individual officer. The determination of an 'unlawful killing' adds weight to this review, whether or not it is requested by the bereaved family.

1.13 Adversarialism in the inquest forum

The Hillsborough Report acknowledged that the adversarial potential of some inquests:

> In contentious cases when insufficient evidence has been gathered to support a criminal prosecution against those whose action or inaction might have contributed to a death, the full weight and expectation of responsibility fall inappropriately on the inquest.[92]

In the absence of a criminal prosecution the courts have required that an investigation into such a death must be independent, thorough and sufficient to identify those

responsible who can be held to account either through the inquest process itself or subsequently through the criminal and civil court.[93]

The description by the Ministry of Justice of an inquest being a relatively informal process may apply to the majority of inquests, which are neither contentious and which do not engage Article 2. Where Article 2 is not engaged, inquests are often uncomplicated. These inquests do not require the holding of preliminary review hearings and the inquest is concluded within six to twelve months of the death[94] with a hearing held, without a jury over a matter of hours.[95] The application of Article 2 requires an investigation of the systems and procedures utilised by state agents in carrying out the armed operation. The inquest will include a consideration of the planning of this operation and if this was carried out in such a way so as to minimise, to the greatest extent possible, the risk to life and whether the force used was absolutely necessary.

[92] Home Office, *Hillsborough: The Report of the Hillsborough Independent Panel* (HC 581, 2012).
[93] Lord Chancellor's Exceptional Funding Guidance (Inquests).August 2015. Promulgated under The Legal Aid, Sentencing and Punishment of Offenders Act 2012.
<assets.publishing.service.gov.uk>uploads>attachment data> file>leg>accessed 13 May 2020.
[94] The Coroners (Inquest) Rules 2013, pt 2, r 8.
[95] Coroners and Justice Act 2009, s 7.

The management of the Article 2 compliant inquest has allowed for greater participation of all interested parties and person through the use of preliminary hearings and the early disclosure of evidence.[96] Preliminary hearings allow the early presentation of competing arguments on all matters relating to the inquest and an opportunity to challenge any adverse decision on a preliminary matter by way of judicial review.[97] These review hearings also allow those participating in the inquest to assist the coroner in determining administrative issues, including the identification of a suitable location for the inquest, the date on which the inquest is to be held and a time estimate as to how long it will last. Other issues that frequently arise at the preinquest review stage and may be a cause of strongly held and opposing views includes

the grant or refusal of anonymity for firearms officers and the commission and use of independent expert witness evidence in a challenge to the official version of events.[98]

Despite the lack of any successful prosecution of police officers, the bereaved's wish to secure an inquest verdict or determination of unlawful killing is likely to be met by a corresponding intention on the part of the responsible police force and officers to prevent the inquest jury from reaching such a conclusion. However, because of the distinct differences between the inquest and a criminal trial, a determination of unlawful killing does not provide a certainty of a prosecution or a conviction on a charge of murder or manslaughter, as the evidence admitted at an inquest may not be sufficient to support a criminal prosecution.

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[96] Chief Coroner Guidance No.22 Pre-Inquest Review Hearings. <www.judiciary.uk.wpcontent>uploads>2013/09>guidance-no-22>accessed 13 May 2020.

[97] Inquest-Liberty-Justice Joint Briefing on Clauses 11–13 of the Coroners & Justice Bill for the Report Stage in the House of Commons, 29 para 44. <justice.org.uk>wp-content>uploads>2015/03>Cor..> accessed 13 May 2020. At a preliminary hearing in the police shooting death of Terry Nicholas, it was submitted on behalf of the Metropolitan Police Service that the coroner had no jurisdiction to hear the inquest because of the operation of The Regulation of Investigatory Powers Act 2000. Therefore, as the coroner could not even be permitted to see any surveillance evidence any inquest could not go ahead as it would be ineffective and would fail to comply with Article 2. Subsequently, an Article 2 compliant inquest went ahead without recourse to this evidence.

[98] Deborah Coles, director of Inquest, has said "We repeatedly see defensive and combative tactics by police lawyers in the growing number of anonymity requests at inquests. This is about justice being done and being seen to be done. Anonymity goes against the spirit of an open and transparent investigation and hinders scrutiny of public officials.
High court quash coroner's anonymity ruling and allows the family of Andrew Hall to see inquest evidence of police officers, INQUEST,7 November 2019 www.inquest.org.uk>high-court-quashcoroners-anon> accessed 13 May 2020.

Although a verdict or conclusion of unlawful killing may lead to renewed pressure on the CPS to review its decision not to prosecute any police officer,[99] there has not since 1969 been a criminal conviction of a police office or state agent for murder or manslaughter in the UK.[100] This apparent contradiction in the outcome between an inquest and a criminal trial was reinforced in the deaths of Richard O'Brien (1995), Christopher Alder (2002), Ian Tomlinson (2011) and Jimmy Mubenga (2013). All of these deaths resulted from the actions of state agents although none were due to a police shooting. Criminal prosecutions of officers followed the verdicts reached in each of these inquests of unlawful killing although each ended in the acquittal of the defendants.

The public inquiry held in 2013 into the 2005 death of Azelle Rodney also concluded with a finding of 'unlawful killing' and led to the officer responsible for firing the fatal

shot being charged and unsuccessfully prosecuted on the offence of murder.[101] Although there have been successful prosecutions of police bodies for offences under health and safety legislation the accountability of individual officers has had to come through a combination of heightened media attention, future death reports, internal disciplinary procedures and civil claims.[102]

1.14 Conclusions

The longstanding role of the coroner and use of the inquest to investigate deaths at the hands of the state have undergone substantial changes to how the investigation is carried out and answers are provided to the four core questions of who died, when,

[99] The Coroners (Inquests) Rules 2013, pt 4 para 25. At the conclusion of the inquiry into the death of Azelle Rodney the matter was referred to the CPS by the inquiry chairman Sir Tom Holland. A prosecution was brought against Tony Long, the firearms officer who had fired the fatal shot on a charge of murder of which he was acquitted.

[100] www.opendemocracy.netopensecurity>death-in-british> accessed 17 May 2020.

[101] Tony Long; *Lethal Force,* (Ebury Press 2016).

At the conclusion of the inquiry into the death of Azelle Rodney the matter was referred to the CPS by the inquiry chairman Sir Tom Holland. A prosecution was brought against Tony Long, the firearms officer who had fired the fatal shot on a charge of murder, of which he was acquitted.

[102] James Sturcke, 'Met police guilty over De Menezes shooting' (The Guardian*,* 1 November 2007) <www.theguardian.com>nov>menezes.jamessturcke2> accessed 18 May 2020. After the conclusion of the inquest into Jean Charles de Menezes a prosecution was brought against the Metropolitan Police Services for Health and Safety offences of which the force was found guilty and a fine imposed.

where and how? Some of the most significant of these changes have included the ban on apportioning blame to any named individual, the prohibition on making any comment upon any criminal or civil liability and the application of Article 2 to these contentious inquests. The continued employment of the local coronial service and the inquest forum to fulfil the state's Article 2 obligations in England and Wales which has been modernised to meet its requirements, remains an anomaly in its otherwise largely adversarial and national legal system.

Criminal prosecutions of firearms officers been uncommon over the timeline of this research, with none having resulted in a successful criminal prosecution for the offences of murder or manslaughter. Consequently, the inquest has continued to provide the bereaved with an important forum in which to hear the detailed circumstances of how their family member died and has offered the bereaved, an opportunity to gain a public acknowledgement of the perceived unlawfulness of the death through a jury verdict or conclusion of 'unlawful killing' and the possibility of a criminal prosecution after a favourable review by the CPS of its decision not to prosecute any firearms officer.

While the requirements of Article 2 have to some extent been met by the modernising legislation of the CJA, there remains a deep dissatisfaction among the bereaved and interest groups, with the continuing absence of automatic public legal funding for these contentious inquests. This lack of funding has been perceived as denying the bereaved an opportunity to participate in the inquest on an equal footing with the police authority and its firearms officers, despite the background of this modernising legislation as 'giving those who are suddenly or unexpectedly bereaved opportunities to participate in coroners' investigations, including rights to information and access to a straightforward appeals system.'[103]

In view of the significant changes that the coronial service has undergone since the automatic engagement of Article 2 to police shooting deaths, the questions that this research raises may be considered to be all the more germane due to increased

[103] Coroners and Justice Act 2009, Background, para 14

awareness of police-shooting deaths and other forms of fatal force used by police officers both in the USA and UK. The progressively vocal and widespread protests at the lack of criminal prosecutions of police officers has intensified the focus on the issue of accountability where a death occurs after contact with an agent acting on behalf of the state.[104]

There is some anecdotal evidence of the adversarial nature of inquests which result from state related deaths. This research considers in detail the effect of the application of Article 2 of the Convention to inquests that result from a police shooting on the inquisitorial function of the inquest. This includes a consideration of whether there has been an erosion of the inquisitorial function of inquests into state-related deaths and if so, the reasons for this and whether the inquest forum provides a suitable forum for the investigation of these. The issues raised are of concern not only to the users of the coroner's court but also to a wider audience. A failure by the state, to provide an effective means of scrutiny of its role and those of its agents, in the death of its citizens calls into question its ability to provide the bereaved with any or any effective accountability for the death of their family member and may in turn lead to a lack of confidence in the state's policing and judicial systems.

Chapter Two examines the literature on the subject of deaths that have occurred after state contact. It examines the literature on the use of the inquest and the concepts of 'justice' and 'accountability' before identifying the growth in adversarialism in the inquest forum and establishing where there is an absence of study. Chapter Three considers the appropriate methodology for the purpose of research in this sensitive and often confidential subject area and the availability of and accessibility of the data required.

Chapter Four provides the important factual foundation for this research and identifies the names of all of those who died as a result of a police shooting, the date on which

[104] The Black Lives Matter Global Network is a chapter-based, member-led organisation whose mission is to build local power and to intervene in violence inflicted on Black communities by the state and vigilantes. <https://blacklivesmatter.com/accessed> accessed 13 May 2020. The recent death of George Floyd, an African American on 25 May 2020, after being pinned down by his neck by a police officer in the U.S. state of Minneapolis sparked widespread protests both nationally and internationally.

each death occurred and the coroner's jurisdiction in which the inquest was held. In reliance upon this information, Chapter Five considers in more detail and with reference to original file materials, the inquests concluded during the first period of the timeline of 1990 to 2000. These inquests were held under the 1980's coronial legislation and provide a bench-mark against which the later inquests can be compared. Chapter Six discusses the inquests that were subject to the investigative requirements of Article 2 and concluded during the period 2001 to 2012 and again, with reference to original inquest file materials, analyses how this affected these contentious inquests. Chapter Seven completes the timeline by discussing the inquests concluded during the period 2013 to 2018 under the modernising legislation of the Coroners and Justice Act 2009.

A qualitative approach is adopted for the purpose of Chapter Eight, which discusses these contentious inquests from the perspective of firearms officers who had been actively involved in these deaths and lawyers who had experience of providing representation at a large number of the inquests held over the timeline of this research. Chapter Nine discusses these contentious inquests from the viewpoint of the bereaved and interest groups using mainly previously published materials and a family campaign public meeting due to family members' reluctance to take part in further research projects. In reliance on the data and information obtained through this mixed quantitative and qualitative approach Chapter Ten discusses the conclusions that can be reached and whether and in what way the questions posed by this thesis are answered.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

The coroner's court in England and Wales is a uniquely positioned inquisitorial forum that is utilised for investigating death in an otherwise adversarial court legal system.[105] In exploring the theory that the inquisitorial role of the inquest has been replaced by adversariality in certain inquests, this review of the literature addresses the historical nature of the inquest forum and the changes that it has undergone in answer to multiple calls for change from official and independent sources. The review explores the literature on the rights provided by the coronial and human rights legislation in the context of the purpose and value of the inquest as a means of investigating deaths that have occurred at the hands of the state or if they otherwise detract from them. This review includes the use of 'justification' in the coroner's court as well as the literature on concepts of accountability in the context of an inquest in which its function is to find facts and can neither apportion blame or administer punishment. This review considers the literature on the concepts of retributive and therapeutic justice and whether they can provide the degree of accountability sought by the bereaved where a state has been involved in the death.

Baker identified the absence of academic literature on the subject of inquests and therefore, much of this review is directed towards sources which include official and independent commissioned reports as well as journal articles covering the subjects of law, criminology, medicine, human rights, psychology and jurisprudence.[106]

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[105] An exception to the adversarial court can be found in the tribunals service and the inquisitorial the First-tier Social Security and Child Support Tribunal when dealing with appeals on welfare benefits.

[106] David Baker, 'Researching deaths after police contact: challenges and solutions (2016) 2(1) Journal of Criminological Research, Police and Practice 15.

2.1 Inquests and the need for reform

The calls for reform of the coronial service has been a consistent theme of government committee and public inquiry reports since the 1930's many of which have stemmed

from the Wright Report.[107] However, substantive change to the legislation governing the practises of coroners proved slow and inadequate to keep pace with modern developments. The failure to modernise the inquest forum became the subject of further scrutiny from Scraton and Chadwick,[108] Burton[109] and Beckett[110] who focused on the need to reform the 1980's inquest legislation to meet the interests of overlooked bereaved and to counter the widespread dissatisfaction with the inquest process.

The coronial service was also the subject of recommendations for reform in the 'Alder Hey'[111] and 'Smith'[112] reports that were produced in response to specific complaints. These arose from the unauthorised retention of human tissue and the deaths of elderly patients at the hands of Dr Shipman, their registered general practitioner. These reports concluded that the current coronial service required modernisation. The need to modernise the inquest forum was a view shared by Freckleton and Ranson[113] who also identified and endorsed the need for change in the coronial service. In particular, Freckleton drew attention to the suggested changes in the form of the Coroners Bill 2006.[114] These changes were based on the proposals for change identified in the Smith

[107] Departmental Committee on Coroners, *Report of the Departmental Committee on Coroners* (Cm 5070, 1936) ('The Wright Committee Report').

[108] Phil Scraton and Kathryn Chadwick, *In the Arms of the Law: Coroners' Inquests and Deaths in Custody* (Pluto 1987).

[109] John Burton, 'Is There Any Future for Inquests and Inquiries?' (1999) 67 Medico-Legal Journal 91.

[110] Clare Beckett, 'Deaths in custody and the Inquest System,' (1999) Critical Social Policy 19: 271.

[111] Department of Health, *The Royal Liverpool Children's Inquiry Report* (HC12-II, 2001) ('The Alder Hey Report'). This inquiry chaired by Michael Redfern concerned the unauthorised treatment of human tissue including that from children.

[112] Home Department, *The Shipman Inquiry Third Report, Death Certification and the Investigation of Deaths by Coroners,* (Cm 5854 2003) ('the Smith Report').

[113] Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press 2006).

[114] Ian Freckleton, 'Reforming Coronership: International Perspectives and Contemporary Developments' (2008) 16 JLM 379, 383.

Report and the Luce Committee Report which criticised the coronial system for failing to provide 'openness, fairness and predictability.'[115]

The report of the Hillsborough Independent Panel drew further attention to the outdated and flawed nature of the inquests of the ninety-six football spectators that had died at Hillsborough in April 1989 and whose inquests concluded in March 1991 with

verdicts of 'accidental death'.[116] The Panel report highlighted the lack of transparency, the failure to conduct a rigorous investigation of core issues and the use of the discretionary power of the coroner in the management and hearing of the inquests. Although all of these governmental and independent reports recommended significant changes to the inquest forum, they did not support its abolition or address any actual or perceived erosion of its inquisitorial character.

Amnesty International also challenged the ability of the inquest to provide a forum in which a rigorous investigation into a death can be conducted.[117] In addition, INQUEST a leading interest group in the field of human rights has challenged the quality of often flawed investigation reports of the PCA and IPCC, a report that was also be provided to the CPS and which contributed to is decision making on prosecutions.[118] In a report on the CPS decisions in relation to deaths in custody, Butler concluded that its ability to carry out a sufficiently sound decision-making process when considering a criminal prosecution of a police officer was essentially due to inefficiency and unsoundness of the working system in the CPS.[119] Butler also

[115] Home Office, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cm 5831, 2003) ('The Luce Review').

[116] Home Office, *Hillsborough: The Report of the Hillsborough Independent Panel* (HC 581, 2012).
[117] Amnesty International, 'Deaths in custody: lack of police accountability' (AI Index: EUR 45/42/00.
[118] Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) p 269.
This is also based on the views of the bereaved who participated in 'Family Listening Days.' That were organised by INQUEST.
[119] Crown Prosecution Service*, Report on Inquiry into Crown Prosecution Service decision-making in relation to deaths in custody and related matters,* (Stationary Office 1999) ('the Butler Report'). [136] Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) p 243 para 73.

concluded that there was no actual favourable treatment of police officers when it came to making decisions on the prosecution although the perception of bias existed.

Despite the implementation of the modernising legislation of the CJA and the establishment of the role of a Chief Coroner a review of deaths and serious incidents identified inconsistencies in the treatment of Article 2 inquests by coroners who held a variance of skills and experiences. The review report recommended that a specialist cadre of experienced and 'ticketed' coroners should be created to preside over Article 2 inquests under the auspices of a National Coroner Service.[136] In this way, persistent inconsistencies of service and the inability of coroners to pursue investigations without

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complete reliance on the IPCC and other agencies might be addressed.[120] Angiolini recognised that Article 2 inquests were frequently complex, contentious and adversarial when one or more organisation found themselves under scrutiny from which a prosecution or other serious consequences might result. However, as in the other reviews, it did not recommend that such inquests should be removed from the coronial forum altogether but focused its recommendation on the treatment required in order for them to be effective.

Scott Bray and Martin drew attention to the increasing scholarly interest in the coronial forum and cited the move away from the previous focus on the historical analysis of the role of the coroner and the case-based research that used coronial findings, inquest proceedings and transcripts.[121] They also referred to the more usual criminological consideration of death investigation practices and systems with a focus on controversial deaths such as deaths in custody, policing-related deaths and extending to deaths in disasters about which Scraton has written extensively, particularly in relation to Hillsborough and who has long queried the use of inquests into controversial deaths.[122] Scott Bray and Martin considered that the significant legal and policy

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[120] Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) p 243 para 72.

[121] Rebecca Scott Bray and Greg Martin, 'Frontiers in Coronial Justice – ushering in a new era of coronial research' (2016) 12(2) International Journal of Law in Context 103.

[122] Phil Scraton and Kathryn Chadwick, *In the Arms of the Law: Coroners' Inquest and Deaths in Custody* (Pluto Pr 1986). See also Phil Scraton, *Hillsborough: The Truth* (Mainstream 2009). [140] David

reform of the coronial jurisdiction has merited further and more recent scholarly attention. This has included consideration by Baker of the impact of Article 2 and the significant reforms it has imposed on inquests and which Baker concluded have been limited by the local structure and nature of the coronial service.[140]

2.2 Human rights in the inquisitorial forum

The importance of the Human Rights Act 1998, which requires coroners to interpret coronial legislation and rules in conformity with rights set out in the ECHR, was reflected in an analysis of its impact upon the inquest process for the bereaved where

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deaths have occurred at the hands of the state. Scott Bray and Martin[123] and Baker[124] focused upon the nexus between coronial practises, criminal justice and human rights. Baker expounds the view that Article 2 represents an evolutionary shift in accountability processes after a death after police contact, whether it results from police custody, a police shooting or a suicide after police contact.

Baker considers how the broadening of the ambit of the inquest that is required by Article 2, has led to a key change to coronial practises by bringing attention to a wide range of causal or contributing acts and omissions by state organisations. Baker draws attention to the use of the narrative verdict in these inquests in the context of the regional nature of the coroner's service and the significant discretionary powers of the coroner. Baker regards that the shift in accountability that Article 2 has brought, is mediated by aspects of the structure of the coronial system. Baker also considers how the dynamic relationship between the coronial system, state and society has continued to evolve as a result of external demands. However, Baker does not consider whether

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Baker, 'Deaths after Police Contact in England and Wales: The Effects of Article 2 of the European Convention on Human Rights on Coronial Practice' (2016) 12(2) International Journal of Law in Context 162.

[123] Rebecca Scott Bray and Greg Martin, 'Frontiers in Coronial Justice – ushering in a new era of coronial research' (2016) 12(2) International Journal of Law in Context, 103.

[124] David Baker, 'Deaths after Police Contact in England and Wales: The Effects of Article 2 of the European Convention on Human Rights on Coronial Practice' (2016) 12(2) International Journal of Law in Context 162.

the nature and extent of the accountability provided by the inquest equates to that sought by the bereaved.

Coronial legal theory and practise have also been the subject of study in the works of Scraton and Chadwick,[125] Beckett,[126] Freckelton,[127] Freckelton and McGregor,[128] Scott Bray and Martin[129] and Baker.[130] Freckelton and McGregor sought to identify the importance of the application of human rights to the inquisitorial process of death investigation while Thomas, Straw, Machover and Friedman have drawn attention to

the practical application of human rights law to inquests in England and Wales.[131] In the context of all categories of state-involved deaths, it has been recognised by Chevalier-Watts that the increasing burden placed on member states to hold a compliant Article 2 investigation and the extension to its ambit that is required to conduct an effective investigation requires a balancing act of the rights of the individual under the Convention with the need not to place too onerous a burden on the state.[132] Baker also considered the role Article 2 had in making inquests into deaths that had occurred at the hands of the state, more extensive in their ambit.[133] However, McIntosh considered the lack of public legal funding restricted the ability of the bereaved to meaningfully participate in these inquests.[134]

[125] Phil Scraton and Kathryn Chadwick, *In the Arms of the Law: Coroners' Inquests and Deaths in Custody* (Pluto 1987).
[126] Clare Beckett, 'Deaths in custody and the Inquest System,' (1999)19 Critical Social Policy 19.
[127] Ian Freckelton, 'Reforming coronership: international perspectives and contemporary developments' (2008) 16(3) JLM 379
[128] Ian Freckelton, S McGregor, 'Coronial law and practice: A human right's perspective' (2014) 21(3) Journal of law and medicine. 2014 584.
[129] Rebecca Scott Bray and Greg Martin, 'Frontiers in coronial Justice – ushering in a new era of coronial research' (2016]) 12(2) International Journal of Law in Context 103.
[130] David Baker, 'Deaths after Police Contact in England and Wales: The Effects of Article 2 of the European Convention on Human Rights on Coronial Practice' (2016) 12(2) International Journal of Law in Context 162.
[131] Leslie Thomas, Adam Straw, Daniel Machover and Danny Friedman, 'Inquests: A practitioner's guide' (3rd edn, Legal Action Group 2014).
[132] Juliet Chevalier-Watts, 'Effective Investigations under Article 2 of the European Convention on Human Rights: Securing the Right to Life or an Onerous Burden on a State?' (2010) 21(3) European Journal of International Law 701.
[133] David Baker, 'Deaths after Police Contact in England and Wales: The Effects of Article 2 of the European Convention on Human Rights on Coronial Practice' (2016) 12(2) International Journal of Law in Context 162.
[134] Sam McKintosh, 'Fulfilling their purpose: inquests, article 2 and next of kin' (2012) 3 Public Law 407.

2.3 Inquests and Therapeutic Jurisprudence

The continued use of an investigative and inquisitorial forum in an otherwise predominantly adversarial legal landscape has led to a re-examination by Coles and Shaw of the coronial service.[135] They have considered the role of the coroner, the purpose of the inquest and limitations on its ability to secure the justice and degree of accountability that is often sought by the bereaved where a family member has died at the hands of the state. Freckleton has drawn attention to the public and scholarly criticisms of the coronial investigations.[136] These have included the inconsistency in the decision-making by the coroner and the lack of rigour in some coroner's decisions. Criticisms have also been made by Angiolini in respect of the limited capacity of the coroner to deal with complex cases in addition to the delay in concluding inquests and the lack of funding for families.[137]

King, Frielberg, Batagol and Hyams considered the relatively new multidisciplinary field of therapeutic jurisprudence.[138] This is defined as the study of how legal systems affect the emotions, behaviours and mental health of people and is said to have a role to play in coronial law and is considered to be a useful tool to ensure that the bereaved are fully involved in the investigative process.[139] Therapeutic jurisprudence is also considered by Winick as a means of providing a forum in which the concerns of the bereaved can be voiced and addressed free of the evidentiary rules the adversarial legal systems impose.[140] In the view of Freckelton while death investigation contains elements of both the adversarial and the inquisitorial, therapeutic justice has emphasised 'the harmfulness of exclusion and alienation of the participants to the legal process'[141] which the provision of public funding for the energetic and competent

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[135] Deborah Coles and Helen Shaw, ' Deaths in Custody — Truth, Justice, and Accountability? The Work of INQUEST' (2006) 33(4) (Social Justice) 136.

[136] Ian Freckelton, Death investigation, the coroner and therapeutic jurisprudence [2007] 15 JLM 1, 2.

[137] Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) p 221, 222.

[138] Michael King, Arie Freiberg, Becky Batagol, Ross Hyams, *Non-Adversarial Justice* (2nd edn. The Federation Press 2014).

[139] Michael King, Arie Freiberg, Becky Batagol, Ross Hyams, *Non-Adversarial Justice* (2nd edn. The Federation Press 2014).

[140] Bruce J Winick, 'The jurisprudence of therapeutic jurisprudence psychology' (1997) 3(1) Psychology, Public Policy and Law 184.

[141] Ian Freckelton, 'Death investigation, the coroner and therapeutic jurisprudence' (2007) 15 JLM 1, 9.

legal representation can make a contribution to reducing the side-lining of the bereaved during the inquest process.[142]

Freckleton considers the efficacy of the inquest process primarily from the view of the bereaved as it is most commonly the bereaved families who are denied to opportunity to voice their concerns and who are not provided with funding for legal representation. Freckelton indicates the interests of the bereaved are being considered, rather than other participants in the inquest, when the view is expressed that where persons can actively participate in the legal (inquest) process, the fairer they view it and the more they can accept a disappointing outcome.[143] Tait and Carpenter considered that where a death has occurred as a result of a suicide, a family may wish to avoid such a conclusion in these or similar circumstances.[144] King considered that his therapeutic role can result in coroners managing inquests in ways that go well beyond the simple finding of facts, thereby subverting the accuracy of death

registration figures and the causes of death.[145] It is also been recognised by King that the balance needs to be achieved between the application of therapeutic jurisprudence and procedural fairness as it is not only the bereaved who are directly affected by the death of an individual, but also many of the other participants in the inquest who have had personal and professional contact with the deceased.[146]

The stated aim of the Coroners and Justice Act 2009 ‘to put the bereaved at the heart of the inquest’ supports the principles of therapeutic jurisprudence in so far as it enables families to participate fully in the inquest of their family member. However, the lack of an automatic grant of public legal funding to bereaved families, where the deceased has died at the hands of the state has been challenged in every independent

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[142] Ian Freckelton, ‘Death investigation, the coroner and therapeutic jurisprudence’ (2007) 15 JLM 1, 9.

[143] Ian Freckleton, ‘Minimising the counter-therapeutic effects of coronial investigation: In search of balance, (2016) 16(3) QUT Law Review 4.

[144] Gordon Tait and Belinda Carpenter, ‘Suicide and the Therapeutic Coroner: Inquests, Governance and the Grieving Family’ 2(3) (2013)) IJCJ&SD 92

[145] Michael S. King, ‘Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model’ (2008) 16 JLM 442.

[146] Michael S. King, ‘Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model’ (2008) 16 JLM 442

review of the coronial service and public inquiry over the past 20 years.[147] This funding omission suggests that the UK government's commitment to the practical application of this aim is limited. Further, the mandatory duty to appoint a jury where a death has occurred after contact with state agents differs from those inquests in which, a death has resulted from an apparent suicide and where state actors have not been involved in which a jury is not required. This difference raises the question of whether the application of the therapeutic approach extends to contentious inquests that arise from a police shooting, as it is the jury and not the coroner who finds facts and provides the scrutiny of the evidence and acts of the other participants and who determine the outcome of the inquest.

MacMahon has described the virtues of retaining the inquest as a form of soft adjudication as including the capacity to provide a significant remedy for the absence of transparency surrounding officer-involved deaths.[148] MacMahon is of the view that such inquests in England and Wales have the advantage of producing information from which steps to punish, absolve, remedy and allay public fears of police wrongdoing might follow. In light of the increasing global activism through the Black Lives Matter

movement and the vocal dissent at the lack of independent investigation and transparency.

2.4 Open justice and Recognition Theory in inquests

In the absence of a criminal prosecution following a death of another at the hands of the state, the inquest provides the bereaved with the only forum in which to achieve any public recognition for their loss, unless it is replaced with a public inquiry. Although not specifically directed towards deaths that have occurred at the hands of the state, the idea of Recognition Theory is based upon the works of Honneth.[149] In

[147] INQUEST, 'Legal Aid for Inquests Timeline' (Feb 2019).
<www.inquest.org.uk › legal-aid-for-inquests-timeline> accessed 10 October 2020.

[148] Paul MacMahon 'The Inquest and the Virtues of Soft Adjudication' (2015) 33 Yale L. & Pol'y Review, 275.

[149] Axel Honneth, *The Struggle for Recognition. The Moral Grammar of Social Conflicts* (Polity Press 1995). Honneth identified the three phases of the struggle for recognition are (i) the demand for *love*, confirming the reliability of one's basic senses and needs and creating the basis for *self-confidence*, (ii) the demand for *rights*, through which one learns to recognise others as independent human beings with

his work, Honneth identified the three phases of the struggle for recognition as first, the demand for love, confirming the reliability of one's basic senses and needs and creating the basis for self-confidence, second, the demand for rights, through which one learns to recognise others as independent human beings with rights like oneself, creating the basis for self-respect, and third, the demand for recognition as a unique person, the basis for self-esteem and a complex and tolerant social life.

McIntosh has proposed that in the context of inquests, Recognition Theory is a means to provide a normative basis on which the bereaved can know the truth about how their family member died to avoid both a sense of injustice and harm.[150] McIntosh contends that an inquest can also serve as a useful tool to provide the bereaved with the public recognition of the losses they have suffered, regardless of whether a criminal trial has taken place, or a civil claim has been won. The coroner, unlike the judiciary in the criminal and civil courts has a unique and longer-term role to play in a death because of the powers provided by the 2009 Act and its 1988 predecessor, whereby the coroner can write a report that is directed towards those that have a role in preventing a recurrence of these fatal events.

As part of achieving recognition for the loss suffered by the bereaved McIntosh seeks to establish that openness and open justice provided in the forum of an inquest, where there has been a death at the hands of the state are linked to the idea of recognition theory.[151] This recognition occurs through the participation of the bereaved and the scrutiny of the actions of a state actor instrumental in the death of the member of their family.

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rights like oneself, creating the basis for self-respect, and (iii) the demand for recognition as a unique person, the basis for self-esteem and a complex and tolerant social life.

[150] Sam McIntosh, 'Fulfilling Their Purpose? Inquests, Article 2 and Next of Kin' (2012) 3 PL 407.

[151] Sam McIntosh, 'Taken lives matter: open justice and recognition in inquests into deaths at the hands of the state' (2016) 12(2) IJL in Context 141.

Scraton drew attention to the importance of the bereaved's ability to meaningfully participate in the inquest in the context of Hillsborough.[152] Scraton also drew attention to the inadequacy of the 'mini inquests' held by the coroner in 1990 regarding those who had died the previous year. These were intended to answer the questions of 'who died, when and where' with the question of 'how' being dealt with at a later date. The coroner had dealt with these three questions by the admission of identification evidence for each individual, medical evidence from the pathologist establishing the cause of death and a West Midlands police officer reading a summary of their evidence to the court. No disclosure of evidence had been provided to family members and no cross-examination was permitted at this stage. The generic hearing dealing with the question of 'how' also deprived families of an ability to examine the precise circumstances of death due to the coroner's decision to exclude this evidence and the lack of disclosure. Subsequently, the coroner's management of these inquests was found to be significantly flawed and the verdicts of 'accidental death' were quashed.

2.5 Inquests, accountability and 'unlawful killing'

The adversarial legal system in England and Wales is based on the premise of retributive justice which is described by Walen as a form of justice committed to the following three principles.[153] These are, first, that those who commit certain kinds of wrongful acts, paradigmatically serious crimes, morally deserve to suffer a proportionate punishment. Second that it is intrinsically morally good if some legitimate punisher gives them the punishment they deserve. Third, that it is morally impermissible intentionally to punish the innocent or to inflict disproportionately large punishments on wrongdoers. It is this adversarial system has led to a deeply held association between accountability and punishment for those charged with an offence. The perception of 'natural justice' as exemplified by the concepts of 'presumed innocence' and 'the right to a fair hearing' are ingrained into the processes of the criminal justice system and are in general understood. Therefore, unless it is otherwise

[152] Phil Scraton, *Hillsborough: The Truth* (Mainstream Publishing 2009).

[153] Alec Walen, 'Retributive Justice' The Stanford Encyclopaedia of Philosophy (Fall 2020 Edition), Edward N. Zalta (ed.), URL<https://plato.stanford.edu/archives/fall2020/entries/justice-retributive/ <accessed 20 October 2020

agreed between the coroner and CPS, the coronial legislation requires inquests to take place after the outcome of criminal proceedings in order avoid compromising the adversarial process of a trial and the prospects of a conviction.

Where an acquittal in a criminal trial has preceded the inquest, the outcome of the inquest jury cannot differ from that of the trial. Aberdeen is of the view that the prohibition on the divergence of the inquest's final determination from the outcome of a criminal trial poses important questions to the implications in law of a criminal acquittal and the incontrovertibility of a criminal verdict.[154] Aberdeen also recognises that tensions can arise between the conflicting decisions of an inquest with those of the adversarial legal system and the coroner's inquisitorial forum and prohibition on attributing blame or expressing any criminal or civil liability.

The few criminal trials that have followed an inquest jury's unlawful killing determination have failed to result in a conviction for murder or manslaughter, adding to the public perception that the state and its agents are 'above the law' and are not held to account.[155] However, even in the absence of criminal prosecutions and convictions, neither the interest groups who act on behalf of the bereaved or other stakeholders in the coronial service have advocated the abolition of the inquest, preferring instead to press for provision of the widely supported grant of automatic legal funding for the bereaved as the means for securing the participation of the bereaved.

The ECtHR has described the purpose behind the investigative obligation of the inquest as being 'to secure the accountability of agents of the state for their use of lethal force' and 'in those cases involving state agents or bodies to ensure their accountability for deaths occurring under their responsibility.'[156] The question of

[154] John M. Aberdeen, 'Blowed off by a Side Wind?' Coronial Inquests Following Criminal Acquittals' (2016) 23 Journal of Law and Medicine 595.
[155] Phil Scraton, *Hillsborough: The Truth* (Mainstream Publishing, 2009).
[156] *Kaya v Turkey* (1988) 28 EHHR 97,161.
See also the case of *Jordan v UK* (2003) 37 EHRR 2, 105. The court emphasised the need to secure 'accountability' in practical terms as well as in theory.

whether a greater frequency of prosecutions achieves accountability in practise is a theme taken up by Baker.[157] In the investigation of deaths after police contact, Baker examines how regulatory bodies construct accountability in legal systems. The absence of any successful prosecutions resulting in a conviction, whether before or after an inquest has concluded, suggests that accountability in the form of retributive justice is not achieved.

Despite the findings of the Butler Inquiry Report into the decision-making process of the CPS and its recommendations for an improved service, for many bereaved families only criminal accountability on the part of the firearms officer will suffice.[158] To this end, many bereaved families have subsequently set up campaigns in an attempt to achieve that aim.[159] The pursuit of criminal accountability after the conclusion of an inquest, has extended to other deaths that have occurred at the hands of the state, most recently in the aftermath of the unlawful killing determination of the jury in the second Hillsborough inquests held twenty-five years after the original inquests. The quashing of the first inquest verdicts and the holding of a second inquest was the result of a long campaign by the family members of the deceased and their supporters.[160]

The response of the bereaved to outcomes of ‘lawful’ and ‘open’ indicates that for some bereaved family members, inquests are insufficient to deliver the degree of accountability they seek. The use of lawful and unlawful killing as jury determinations

has been criticised as misleading. Rogers proposes that these outcomes should not only refer to the offences of murder and manslaughter but should refer to the commission of any criminal offence that has a causal link to the death.[161] Rogers also

[157] David Baker, *Deaths after Police Contact: Constructing Accountability in the 21st Century* (Palgrave Macmillan 2016).

[158] Crown Prosecution Service, *Inquiry into Crown Prosecution Service Decision-Making in Relation to Deaths in Custody and Related Matters* (TSO, August 1999) (‘The Butler Report’).

[159] In 1997, the United Families & Friends Campaign was formed, which brought together a coalition of those affected by deaths in police, prison and psychiatric custody and supports others in similar situations. <uffcampaign.org> accessed 15 May 2020.

[160] Kevin Sampson and Hillsborough Justice Campaign, *Hillsborough Voices: The Real Story Told by the People Themselves* (Ebury Press 2016). See also Hillsborough Justice Campaign www.contrasr.orghillsborough>aims> accessed 21 December 2020.

[161] Jonathon Rogers, ‘”Lawful killing” conclusions in inquests are misleading’ (UCL, 2014) <www.ucl.ac.uknews>’sep>lawful-killing’-con.. . .> accessed 6 June 2020.

argues that if the law were to be amended in this way, the conclusion of 'unlawful killing' would be much more likely, in the inquests of those who had been wrongly killed. In instances where no criminal prosecution has followed a finding of 'unlawful killing' such an outcome may be sufficient to command respect from the public and regarded as the final public word on the incidence from the perspective of all parties. Voght and Wadham have expressed the view that the continued use of a determination of unlawful killing at an inquest makes it difficult for a bereaved family to understand how it does not lead to a criminal prosecution even if not to a conviction.[162]

The significance of a verdict of unlawful killing was recognised in the recommendation for the reinstatement of the use of this term as an inquest verdict by the report of the Independent Northern Ireland Committee. In this report it was said that such a determination would provide a means of securing some sense of justice for the bereaved in the absence of criminal prosecutions.[163] For families in Northern Ireland the replacement of verdicts with 'findings' and the prohibition of the use of 'unlawful killing' as a determination has served to enhance the sense of injustice already caused by the long delays in concluding the inquests of those who died at the hands of the state or state-sponsored agents during 1970's.[164] Kirchengast has viewed the retention of the use of unlawful killing by inquests held in England and Wales as providing a persuasive step towards criminal accountability.[165] This has been implemented by the bereaved through the exercise of a right to seek a review by the

CPS in accordance with The Victims Right to Review Guidance of the decision not to instigate criminal proceedings.[184]

[162] Greta S. Voght and John Wadham, 'Deaths in Custody: Redress and Remedies' (2003) Liberty, The Civil Liberties Trust 36.

[163] Committee on the Administration of Justice, Pamphlet No. 18, 'Inquests and Disputed Killings in Northern Ireland' (CAJ, January 1992). See also The Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 (as amended), r 16 22 and 23.

[164] Committee on the Administration of Justice, 'Memorandum to the Joint Committee on Human Rights' (2003) p 76, 78. <https://publications.parliament.uk>jtselect>jtrights> accessed 20 December 2020.

[165] Tyrone Kirchengast, 'Victims' Rights and the Right to Review' [2016] IJCJ&SD 5(4) 103, 115.

2.6 Self-defence and the excuse of 'justification'

The law of 'self-defence' has been the subject of critical commentary in academic literature and its need for reform.[185] The concept of an 'honest but mistaken' belief as the justification for the use of fatal force by firearms was scrutinised by Foster and Leigh.[186] This scrutiny was in the context of the shooting of Jean Charles de Menezes and the decision of the ECtHR in *Armani Da Silva v United Kingdom*.[187] The unwillingness of the CPS to prosecute firearms officers was attributed to the current state of the law as the reason prosecutions were the exception in fatal police-shootings as the defence of 'honest mistake' is particularly easy to navigate successfully and the reason the CPS declined to prosecute the firearms officers in the shootings of Harry Stanley and Jean Charles de Menezes.[188] Norrie suggests that the defence of 'justification' should be reconsidered on the basis of whether 'it is a justified killing gone wrong' or 'an unjustified killing for which an excusatory defence is required'.[189]

2.7 The inquest as an adversarial forum

Scraton has acknowledged that certain inquests in which the death has occurred at the hands of the state have developed an adversarial tone.[190] The Angiolini report also found that there was widespread agreement among users of the coroners court that these inquests had become adversarial:

[184] Director of Public Prosecutions for England and Wales, Victims Right to Review Guidance: The Crown Prosecution Service (2014)
<www.cps.gov.uk › legal-guidance › victims-right-revie...> accessed 20 October 2020.

[185] Fiona Leverick , *Killing in Self-Defence* (Oxford University Press 2006).
See also; Clemency Wang, 'The Police are innocent as long as they honestly believe: The human rights problems with English self-defence' (2018) Columbia Human Rights Law Review 373,414

[186] Steve Foster and Gavin Leigh, 'Self-defence and the right to life; the use of lethal or potentially lethal force, UK domestic law and article 2 ECHR,' (2016) European Human Rights Law Review 389.

[187] *Armani Da Silva v United Kingdom* (App No 5878/08, 30 March 2016).

[188] Alan Norrie, 'The Problem of Mistaken Self-Defense: Citizenship, Chiasmus, and Legal Form' New Criminal Law Review: An International and Interdisciplinary Journal, vol 13(2) 2010, 376.

[189] Alan Norrie, 'The Problem of Mistaken Self-Defense: Citizenship, Chiasmus, and Legal Form' New Criminal Law Review: An International and Interdisciplinary Journal, vol 13(2) 2010, 357,378

[190] Phil Scraton, *Hillsborough: The Truth* (Mainstream 2009).

> The reality is that Inquest hearings into death in police custody are almost always adversarial in character. This has been the unanimous

> opinion of Coroners, lawyers and families who have given evidence to this review.[166]

The adversariality of these inquests is a view shared by police officers.[167] This is a view that is also held by the bereaved as described by Shaw and Coles.[168] However, the Supreme Court of Ireland confirmed in *Ramseyer v Mahon* that the entitlement of an interested party to information held by the coroner did not have the effect of converting an inquisitorial hearing into an adversarial one.[169] The investigative nature of the inquest was again emphasised in the decision of the Court of Appeal in *Maughan.*[170] This view has also been emphasised by the Ministry of Justice's in its Review of Legal Aid for Inquests.[171]

The continuing suitability of the inquest has also been the subject of investigation in two major reviews by Casale[172] and the IPCC.[173] These reviews have concluded that the coronial system provides a thorough rigorous and independent investigation into contentious deaths. MacMahon identifies inquests as having an important role where the death has occurred at the hands of police or prison officers.[174] MacMahon contends that an inquest in these circumstances can establish facts more squarely than other legal proceedings because their verdicts do not carry coercive consequences and asserts that such inquests would further the need for accountability, the collection and

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[166] Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) p 13 para 45.

[167] Josh Loeb, 'Police shooting prosecutions: No law change needed by investigations but must be speedier' (Police Oracle, 15 July 2015) <www.policeoracle.comnews>2015>July>15>police< accessed 16 May 2020.

[168] Deborah Coles and Helen Shaw, 'Learning from Death in Custody Inquests: A New Framework for Action and Accountability' (2012) <www.inquest.org.uklearning-from-deaths-in-custody> accessed 16 May 2020.

[169] *Ramseyer -v- Mahon*, [2005] IESC 82.

[170] *R (Maughan) v Senior Coroner for Oxfordshire* [2019] EWCA Civ 809.

[171] Ministry of Justice, *Final Report: Review of legal aid for inquests (*CP39, 2019).

[172] Silvia Casale, 'Report of the independent external review of the IPCC investigation into the death of Sean Rigg.' This was an IPCC independent review conducted by Dr Silvia Casale with the support of James Lewis QC and Martin Corfe between November 2012 and April 2013 www.seanriggjusticeandchange.comReview Re….> accessed 20 September 2020.

[173] IPCC, 'Review of the IPCC's work in investigating deaths; Final Report' (2014) www.policeconduct.gov.ukresearch-learning> accessed 10 October 2020.

[174] Paul MacMahon, 'The Inquest and the Virtues of Soft Adjudication' [2015] 33 Yale L. & Pol'y Rev. 275.

dissemination of information about risky activities and help the bereaved come to terms with a traumatic death.[175]

In MacMahon's view the inquest procedure is free from the evidential rules of the criminal and civil courts and is therefore, more likely to be able to establish the truth of the circumstances leading up to the death without directly threatening any individual with a deprivation of liberty or a financial penalty.[176] Voght and Wadham contend that there are good reasons for arguing that it is in the public interest to obtain the truth at an inquest and this is sufficient justification for forcing answers to questions by using the sanction of contempt of court, even if this forces the witness to admit they have committed an offence on the promise that this evidence would not be used against them in a criminal court.[177]

It was recognised by Cross and Graham that inquests into contentious deaths during the period 1990 to 2000 usually considered only the immediate circumstances of how the deceased had died and were frequently concluded with a relatively short final hearing.[178] Since the application of Article 2 to inquests, users of the coroner's court have recognised that Article 2 inquests have become increasingly complex and lengthy and is an issue recognised by the Chief Coroner. Despite the official insistence that the inquest continues to be an inquisitorial forum, Quan has acknowledged that the inquest forum has become increasingly adversarial, with coroners being described as 'less like inquisitors and more like referees of legal combatants' particularly where a

[175] Paul MacMahon, 'The Inquest and the Virtues of Soft Adjudication' [2015] 33 Yale L. & Pol'y Rev. 275.

[176] Paul MacMahon, 'The Inquest and the Virtues of Soft Adjudication' [2015] 33 Yale L. & Pol'y Rev. 275.

[177] Greta S. Voght & John Wadham, 'Deaths in Custody: Redress and Remedies' (2003) Liberty, The Civil Liberties Trust 37. The public inquiry into the death of Azelle Rodney had assured firearms officers that there would be no prosecutions unless new evidence indicated that a crime had been committed.

[178] Caroline Cross and Neil Garnham, *The Inquest Book: The Law of Coroners and Inquests* (Hart Publishing 2016).

death has occurred at the hands of the state.[179] The increasingly adversarial nature of the inquest was also recognised in a more recent review of deaths in custody conducted

by Angiolini.[180] The review also found that the view that these inquests were adversarial was shared by coroners, lawyers and families and included those of INQUEST in whose opinion that 'In reality the inquest has frequently been approached by families and other bodies as an adversarial forum.'[181]

2.8 Conclusions - a gap in the literature

The literature on coroners and inquests includes subject areas that encompass history, jurisprudence and law, psychology and medicine. Previously, much of the literature focused upon the historic nature of the inquest forum, which came under scrutiny in the form of government and independent reports. These reports consistently identified the need for the modernisation of the coronial service and the unfair treatment the structure of the inquest forum caused to the interests of the bereaved.

Since the application of the procedural, investigative limb of Article 2 to inquests, academic interest in the subject of death investigation has increased. The decision to retain the inquest as the forum in which to meet the state's investigative obligation by the implementation of modernising legislation has also contributed to the study of the coronial service. The inquest has come to be viewed as a forum in which the bereaved may seek the accountability of the agents of the state in alternative ways to the adversarial structures of the civil and criminal courts. Consequently, academic literature has extended to a consideration of the nature of the accountability the coronial forum provides to the bereaved and an examination of the concepts of therapeutic jurisprudence and recognition theory in the context of inquests. However,

[179] Douglas Quan, 'Dying to be heard: Expert views on how to resuscitate our inquest system' (3 November 2014) <o.canada.com>health-2>improving-accountability> accessed 16 May 2020.

[180] Home Office, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) ('The Angiolini Report'). Dame Elish Angiolini conducted the review of serious incident and deaths in custody. <www.gov.uk>Crime, justice and law>Policing> accessed 16 May 2020.

[181] INQUEST – 'How the inquest system fails bereaved people', 28. <iapdeathsincustody.independent.gov.uk/. . ./INQUEST-Briefing-on-Coronial-Reform-> accessed 6 July 2020.

there has been a growing realisation and appreciation of the increasingly adversarial nature of an inquest where the death has occurred after state contact, although it is not a perspective that is widely shared by the courts or official bodies.

In the scrutiny of the coronial service and the engagement of Article 2 to inquests, the literature has adopted a positive approach to this development and the requirement it

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has brought in ensuring the participation of the bereaved. Since the implementation of the HRA criticisms of the coronial service continued to be directed at the outdated nature of the coronial service under the 1980's legislation, its local character and the idiosyncratic approach of the coroner. The application of Article 2 has led to a consideration in the academic literature of the effectiveness of the inquest to provide any degree of accountability to the bereaved for the death of their family member in state-related deaths.

More recent literature suggests that inquests to which Article 2 is engaged have become increasingly adversarial often contributed to by the violent nature of the death and the contentious circumstances in which it occurred. The focus of much of the literature has been upon how Article 2 has benefitted the bereaved in the inquest forum. However. the role of Article 2 in eroding the inquisitorial function of the inquest and the detriment it may present to the bereaved and other stakeholders is a theme that has been less explored. This research identifies the reasons for the growth of adversariality in the inquest and aims to consider the views of the bereaved and their supporters as well as those of the firearms officers, which tend to be less well known.

This research theorises where there has been state involvement in the death, the inquisitorial nature of the inquest has been eroded to the extent it has become an adversarial forum to the detriment all participants in these contentious inquests. Rather than providing the inquisitorial 'no blame' hearing that is intended it is in reality, another adversarial forum that operates outside of the procedural and evidential safeguards provided in the otherwise adversarial legal system of England and Wales.

In exploring this theory, this research adopts a structured analysis of all deaths that occurred at the hands of the state as a result of a shooting by police firearms officers,

over a timeline that has seen significant and substantive changes to the coronial service. This research uses original inquest file material as well as case studies and interviews from which analysis can be made and conclusions reached to the question posed by this thesis, a discussion of which is expanded upon in the next chapter.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

The methodological challenges to researching deaths after police contact in England and Wales have been previously recognised and attributed to a lack of access to data, the sensitivity of the information required and the limited nature of the academic literature.[182] In addition, the local nature of the coronial service, the individualised approach of the coroner and the nature and circumstances of these deaths all dictate that the inquests are likely to demonstrate a wide range of differences, thereby increasing the difficulty of making comparisons between them. Notwithstanding these difficulties, the central questions that this thesis seeks to test are the following:

(i) Have inquests into deaths at the hands of the state become adversarial?[183]

(ii) Is the implementation of Article 2 responsible for this change?

(iii) To what extent has the use of 'lawful' and 'unlawful killing' as a verdict or conclusion in inquests into contentious deaths played a role?

(iv) Do inquests into deaths at the hands of the state remain fit for purpose?

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[182] Baker describes the methodological challenges in researching deaths after police contact such as access to data, sensitivity, limited academic literature and bias and the use of non-traditional methods and an innovative approach.
David Baker, 'Researching deaths after police contact: challenges and solutions (2016) 2(1) Journal of Criminological Research, Police and Practice 15.

[183] For the purposes of this research 'deaths at the hands of the state' are defined as deaths arising from a police-shooting and the inquests that followed as 'contentious inquests'.

To avoid sole reliance on the willingness and availability of the various interested parties and their legal representatives to participate in interviews, it was necessary to consider an alternative source of data and methodology. This data would allow the comparison of inquests across a sufficiently broad timeline and accommodate the local nature of the coroner's service without preventing meaningful analysis.

3.1 A quantitative approach: Identifying the contentious inquests

The classification of deaths at the hands of the state is broad and varied as it encompasses deaths that have occurred in police custody, in prison and immigration centres, after a police vehicle chase, suicides that have taken place after police contact and police shootings. Article 2 may also be engaged where the deceased has died in a hospital setting, a mental health unit or while under a Deprivation of Liberty Safeguards Order.[209] Many deaths that have followed some form of state contact have occurred in highly contentious circumstances and many them have produced global media attention and public interest, particularly in light of the increased engagement of interest groups such as the Black Lives Matter movement.[184]

Initially, it had been intended to focus upon state-related deaths that had occurred in various settings and in some of the most controversial of circumstances.[185] However,

[184] Founded in 2013, the Black Lives Matter Global Network Foundation is a Black-led organisation that supports Black led movements across the globe. <blacklivesmatter.com> accessed 20 September 2020. In October 2020 BLMUK acquired legal status and became known as Black Liberation Movement UK.

[185] The inquests of Kingsley Burrell and Mikey Powell are just two of the inquest files that were originally accessed in 2017 at Birmingham coroner's court where they are held in storage.
Mr. Burrell died on 31 March 2011 in a mental health unit after being transported by police to a place of safety a few days earlier. In the intervening period Mr. Burrell had become injured and he was taken by the police to A&E where a struggle ensued after which, he was taken back to a mental health unit where he subsequently died of hypoxic/ischaemic brain damage due to cardio-respiratory arrest. The interested parties included the Mental Health NHS Trust, the police, the ambulance service, and individual members of staff as well as the bereaved family.
Mikey Powell died in police custody on 7th September 2003. The inquest was resumed after the conclusion of a criminal trial as the family asserted that the criminal proceedings had not dealt with the manner in which Mr. Powell had been restrained and officers had failed to transport him to hospital. [212]
INQUEST carries out comprehensive monitoring and collating of statistics relating to deaths in prison, police custody and following police contact, and deaths of immigration detainees. INQUEST has compiled a unique data set derived from its own monitoring and casework. During the period 1990 to 2018 INQUEST recorded 1694 deaths resulting from police custody, police pursuit, road traffic incidents and police shooting and not including deaths that occurred in prisons or immigration centres.

it became apparent from an early stage in this research, that the inclusion of all staterelated deaths that occurred during a period that included the implementation of the HRA and the CJA, were diverse and unlikely to provide any sufficient degree of uniformity for the purpose of making comparisons.[212] In addition, there were several significant differences in the treatment of these deaths, which included the identity of the authority or official body that was responsible for conducting an investigation into

[209] Chief Coroner's Guidance No16A: Deprivation of Liberty Safeguards (DoLS). Where a death has occurred on or after 3rd April 2017 any person subject to a DoLs (i.e. a deprivation of liberty formally authorised under the Mental Capacity Act 2005), that person is no longer 'in state detention' for the purposes of the 2009 Act.

the circumstances of the death. The identity of the investigatory body was dependent on whether the death had resulted from police contact, had occurred in a police station a prison or immigration centre or in a hospital or mental health unit. The PCA and its successors the IPCC and IOPC, the Prisons and Probation Ombudsman (PPO)[186] and the relevant National Health Trust[187] would variously be responsible for investigating the death and preparing a report that would ultimately be provided to the coroner for the purpose of the inquest.

Therefore, to be able to draw meaningful comparisons and conclusions from this research, it was necessary to identify a sufficiently numerous but nevertheless manageable group of inquests where the death had occurred at the hands of the state and in which Article 2 of the HRA was engaged. Further, this group of inquests had to share a sufficiently similar number of characteristics, that despite the local variations in the coronial service were attributable to the legislation in effect at the date the inquest was concluded, rather than being due to the idiosyncratic nature of the coroner. These inquests had to demonstrate similarities regarding the investigation of the death, the character of the interested parties and persons and in the nature and extent of the management of the inquest and its final hearing.

The category of deaths that was identified as meeting these criteria were the civilian deaths that had resulted from a shooting by police firearms officers.[215] It is these

[186] The PPO was formed in 1994 as a result of the prison riots which took place in 1990 at Strangeways Prison, Manchester.

[187] NHS trusts were established under the National Health Service and Community Care Act 1990. [215] This category excludes any deaths of police officers in the line of duty and as occurred in the death of firearms officer Ian Terry in 2008 during a police training exercise.

deaths that shared the common feature of being subject to an investigation by a third party, a decision by the CPS as to any prosecution of a police officer and a mandatory jury inquest by the coroner. These deaths had often occurred in some of the most contentious of circumstances and automatically engaged the application of Article 2 after the coming into force of the HRA. They were also deaths that were the most likely to have concluded with an inquest jury verdict or conclusion of lawful or unlawful killing. This particular category of deaths also had the advantage of having formed a sufficiently large but closed and identifiable group of inquests that were held during the identified timeline. In the absence of a single, complete and reliable list of these police-shooting deaths with the details of who, where and when and the outcome of the inquest, it was necessary to consult and cross-reference several official and unofficial sources.

The local nature of the coronial service, the idiosyncratic practices of the coroner and the age of the police shooting inquests that pre-dated the Human Rights Act made it unrealistic to expect that complete inquest file materials and transcripts for a sufficiently large number of inquests would be available, even where access to this information was permitted by the coroner due to its sensitive and often confidential nature. Therefore, the selection of the totality of the inquests that resulted from a police-shooting which occurred over a specific timeline, required a means by which to analyse and compare them from more readily obtainable material. This was available in the form of the date of death and date of inquest outcome as well as the time taken for the final inquest hearing as this information was available from inquest file material as well as a number of published sources.

3.2 The timeline

Having established a specific category of deaths which are defined for the purpose of this research as the 'contentious inquests,' the next step was to identify an appropriate timeline, during which these deaths had occurred and their inquests concluded. This timeline was required to be sufficiently long to allow meaningful comparisons to be made between the contentious inquests and the period in which they were held. The timeline of 1990 to 2018 was identified as providing a period during which the inquest

forum experienced three distinct periods of significant and substantive change. The identified timeline included inquests for which there was a likelihood that, files may not have been retained within local coroner jurisdictions, as it fell on the outer limit of the fifteen-year period coroners were ordinarily required to retain this material.[188] Therefore, any earlier period in which contentious inquests had been held would be less likely to provide original inquest materials. Extending the timeline to a date past 2018 also created difficulties in acquiring the information necessary for this research as inquests were unlikely to have been concluded due to ongoing investigations and the possibility of a criminal prosecution.

The timeline of 1990 to 2018 provided a sufficiently long and diverse period during which deaths at the hands of the state occurred, as it is made up of three distinct periods of coronial law. The first of these comprises the deaths that occurred and the inquests that were held during the period 1990 to 2000. Over these specific years, the contentious inquests were held in accordance with the 1980's legislation as the HRA was not in force until October 2000 and the application of Article 2 to inquests was solely by way of reliance on the Convention, which the UK had both signed and ratified in 1950's but, which was not directly applicable in the courts of England and Wales.

The second period identified occurred between 2001 and 2012, during which Article 2 was enacted into domestic law through the HRA although inquests were still subject to The Coroners Act 1988 and The Coroners Rules 1984. The third and final period of 2013 to 2018 required inquests to be Article 2 compliant and were subject to the modernising legislation of the Coroners and Justice Act 2009. Although these periods are not equal in length, each provided a sufficient number of contentious inquests from which analysis and comparisons could be made, notwithstanding the disparities exhibited in the local nature of the coronial service. Extending this research to any earlier date made it less likely that inquest files had been retained and would have also rendered the number of inquests in the first of these timelines, disproportionate to those

[188] The Coroners Rules 1984, r 56. A coroner must retain documents in connection with an investigation or post-mortem examination for 15 years.

inquests identified in the second and third periods without necessarily being able to add any additional meaningful data. Therefore, by adopting this specific time-line it was anticipated that the deaths falling within each period of the timeline would provide sufficient material from which analysis could be made.

As no single official body appeared to keep a complete and wholly reliable record all deaths that had occurred as a result of a shooting by armed police officers during 1990 to 2018, it was necessary to cross reference several official and unofficial sources that kept some information of these deaths to compile a complete and verifiable record. In conducting this data collection, information was collected from the Home Office; the Police Conduct Authority (PCA); the Independent Police Complaints Commission (IPCC); the Independent Office of Police Complaints (IOPC), the Office for National Statistics (ONS): the interest group INQUEST and the Institute for Race Relations as well as publications by former firearms officers. By using a combination of all of these sources of information, it was possible to identify a definitive list of the names of the person who died, when they died as well as the coroner's region or area in which the inquest was held and its verdict or conclusion.

3.3 The inquest files and data collection

A complete list was compiled of the seventy-one individuals whose deaths had resulted from a fatal shooting by a police firearms officer in thirty-four different coroner's different regions and areas. Due to the amalgamation of several of the coroner's regions and areas since 1990, it was necessary to be aware that the coroner's jurisdiction in which the death had occurred and to which it had been reported, might no longer be the same as described in the up-to-date list of coroner's areas published by the Chief Coroner. The identity of the coroner's jurisdiction in which the shooting had occurred was ascertained through publicly available information websites such as the Society of Coroners for England and Wales and local authority coroner websites, which provided details of the geographical areas it covered as well as the name of its current senior coroner. [189] In addition to media reports and press releases by interest groups of the final hearing and outcome of the inquest.

[189] Over the years the coroner's areas (previously known as regions) have changed with many being amalgamated to form large coroner areas. However, if the place of death is known, an internet search can identify the area each current coroner area covers. However, on some occasions, because of the

As the best source of the material required for this research was contained in the original inquest files, access to these for the contentious inquests concluded during the period 1990 to 2012 was requested from the respective senior coroner in whose jurisdiction the death had occurred.[190] Omitted from these requests were the two

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inquests that were not resumed after their initial opening.[191] Where the coroner's jurisdiction had been amalgamated with one or more other regions or areas since 1990, a request to one senior coroner had to be redirected to another for access to information.[192] Access to the files of the three inquests converted to inquiries and the most recent group of inquests held between 2013 and 2018 was not requested, as a number of these remained ongoing and were awaiting a final hearing, Other inquests in this period were the subject of potential or ongoing of civil litigation or undergoing review by the CPS of its decision not to prosecute any firearms officer involved the fatal shootings in that period.   For the majority of these inquests in the third period of this research, much of the information sought was available from online reporting, through press releases, news articles as well as from publications by interest groups. In a limited number of inquests, material from official sources was made available where the inquest was of particular public interest.[193]

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changes to jurisdictional boundaries an approach to the coroner responsible for the inquest at the date of death may differ from the coroner that currently has jurisdiction.

[190] The term 'jurisdiction' includes both the 1980's legislation of coroners 'regions' which was changed by the modernising legislation of the CJA to 'areas' and have also been referred to as 'districts'. Coroners and Justice Act 2009 sch 2. The names of these jurisdictions are given as used by the Chief Coroner and includes areas that have been amalgamated. The coroner's jurisdictions are as designated in the Report of the Chief Coroner to the Lord Chancellor, Fifth Annual Report: 2017–2018, Annexe C. <www.gov.uk/government/publications> accessed 14 May 2020.

[191] The inquests of David Ewin and James Ashley were not resumed after unsuccessful criminal prosecutions of police officers and the transcript of the inquest of Mark Duggan was subsequently officially available online while the inquest of Anthony Grainger was converted to an inquiry.

[192] At the commencement of the Coroners and Justice Act 2009, there were ninety-nine coroner jurisdictions which in 2018 had been reduced to eighty-eight. It is intended to eventually reduce these to seventy-five. Reports of the Chief Coroner to the Lord Chancellor. First Annual Report: 2013–2014. <www.gov.uk/government/publications> accessed 17 May 2020.

[193] Examples of this are found in the inquests of Jean Charles de Menezes and Mark Duggan.

Difficulties in collecting these sensitive data were reflected in the responses received from senior coroners in answer to the request to access original inquest files.[194] These responses included three outright refusals from coroners in whose jurisdiction eight of the contentious inquests had been held during the period 1990 to 2012. Two coroners cited issues of confidentiality and another gave no reason at all for this decision. Seventeen senior coroners in whose jurisdiction twenty-eight of these contentious inquests had been heard during the period of 1990 to 2012 failed to respond despite numerous repeated requests, Twelve senior coroners gave access to sixteen original files and another provided information by electronically stored transcripts and rulings.[223]

Where access to original inquest files was granted a suitable date was agreed with the coroner or administrative staff on which to visit that particular coroner's court to view

the file, as these often had to be retrieved from off-site storage locations and as space at the court building was frequently at a premium. The storage of inquest files varied considerably among the jurisdictions, with some regions or areas having disposed of all or the majority of the file having been required to retain it only for fifteen years.[195] One jurisdiction was only able to provide information on whether the requested files had been retained if provided with the date on which the inquest was concluded by the jury. This date was obtained from a copy of the relevant death certificates stored by the General Registry Office.[196]

The review of original inquest files took place predominantly at the respective coroner's court building due to the confidential nature of the material. On each occasion the date for this review was pre-arranged as space in which to carry out the review of the file was often limited. Other inquest files had to be inspected at the secure off-site facility in which they were stored, due to the large number of boxes, the

[194] See Appendix 3 for the full record of responses to request for access to original inquest material. [223] See Appendix 1.However, this particular death was excluded in this research as it concerned the death of a firearms officer during a police training exercise, rather than that of a civilian.

[195] Coroners Rules 1984 r 56 required the retention of any document (including recordings) in the possession of a coroner in connection with certain reported deaths for fifteen years. The Coroners (Investigations) Regulations 2013 reg 27 replicate this provision although the Chief Coroner may direct such documents be held for a longer period.

[196] The date of the concluding day of the inquest was recorded on the death certificates of Derek Wallbanks and James Brady.

logistical difficulties and expense involved in having them taken to the coroner's court. Another file could not be located at all, indicating that it had either been misfiled or destroyed.[197]

The inquest files demonstrated a lack of uniformity among the coroner's jurisdictions in the approach taken to their retention. The files differed significantly as to the amount of material that had been retained from jurisdiction to jurisdiction as well as within the same jurisdiction. Some files contained only the coroner's notebook and personal copies of documents, letters and handwritten notes of evidence, while other files consisted of all of these documents in addition to photographs, maps, plans, official reports and in a few case files a complete typed transcript of evidence. By applying the same set of questions to each of these contentious inquests, it was anticipated that the file contents would reveal any patterns arising from the treatment of the inquests

by the coroner in each of the three time periods identified, both during the preparatory stages and at the final hearing.

The information sought from each original inquest file to which access was permitted comprised the following:[198]

1. The identity and number of Properly Interested Persons (PIPs) or Interested Parties (IPs).
2. The ambit of the inquest.
3. Were the IPs or PIPs were legally represented?
4. The number of witnesses (oral & documentary) called to give oral evidence or gave 'read' evidence.
5. If Rule 22 (right not to incriminate yourself) was utilised?
6. Other evidence used at the inquest e.g. CCTV, surveillance footage.

[197] In one instance an inquest file was not found in storage although permission for access had been granted by the senior coroner.
[198] See Appendix 4 for the list of questions used for the compilation of the information sought from all of the inquest files to which accessed was permitted.

7. The number of pre-inquest review hearings (PIRH) held in preparation for the inquest.

8. Pre-inquest disclosure – what and to whom given and when?

9. Legal questions arising at both the preliminary stages and the substantive inquest, e.g. application for Public Interest Immunity, anonymity of witnesses.

10. The submissions by PIPs/IPs as to the verdicts or conclusions that can be left to the jury.

11. The time taken to hear the inquest.

12. Whether there was a Prevention of Future Deaths Report following the conclusion of the inquest?

The original inquest files also provided the identity of the interested parties and their legal representatives to whom requests for an interview could be made. Where original files could not be accessed, local and national media reporting often provided a useful source of information as these frequently printed the name of the coroner and the court where the inquest was being heard, the police force involved in the fatal shooting and the names of the legal representatives. Often the names of firearms officers both in the file materials and the media reports were referred to only by a cipher.

3.4 Contentious inquests and other sources of data collection

Where inquest files could not be accessed other sources of relevant data were found in local media reports as well as in national news reports. The media coverage was a valuable source of information as some inquests were covered extensively with others only providing reports on the first and last days of the inquest's final hearing, when verdicts or conclusions were reported. Collectively this material provided sufficient material from which the length of the inquest could be calculated with reasonable accuracy.[199] Interest groups also routinely published briefing papers, media releases and journal articles, which provided the date of the final hearing, the time taken to

[199] The actual number of days on which evidence was heard can be ascertained from looking at the original inquest files as rest days or days taking care of other routine business were often factored into these inquests if they were likely to be lengthy. Similarly, an inquest could be interrupted by a Judicial Review application on issues that were relevant to the inquest proceeding.

conclude it and the outcome of the inquest as providing commentary and insight into the inquest from the perspective of the bereaved. Accounts of the history of armed policing in the UK and of armed operations by former firearms officers, provided useful corroborating information about a number of the police-shooting deaths.

3.5 Analysis of data collected

In order to provide structure to the material collected from the inquest files and other sources about the seventy-one police-shooting deaths that occurred during the period 1990 to 2018 a Table format was utilised. As the information from the various sources differed considerably in the details it provided the Tables were considered to be the most effective format in which to demonstrate comparable information that was available for all the inquests and from which analysis could be made for the purpose of answering the questions posed by this thesis.

3.6 Case studies

Where inquest files were accessed, this original material was also used for the case studies in the following chapters as a means of demonstrating how these inquests were managed by the coroner with particular reference to the role of the bereaved in them. As a significant number of the inquests had been held many years earlier, the file material provided a source of information that was not reliant on the memories or availability of those who had taken part in the inquest as interested parties or persons. As a single contentious inquest from each period of the timeline was unlikely to provide sufficient information for the purposes of making comparisons, all of the inquest files that were accessed were used to form the case studies in the first and second of the identified periods. These case studies, therefore, could contribute to a testing of the theoretical framework of this thesis, that the inquisitorial forum of the inquest had been eroded by the engagement of Article 2. As original file materials for the inquests held in the third period were mostly unavailable, due to their ongoing nature or the possibility of criminal and civil litigation, the smaller number of case

studies of this period had to rely largely on published material. However, as much of this information was available from both official sources and more recent unofficial sources it was more detailed than the published reports of the inquests from earlier periods.

3.7 A qualitative approach: Interviews

Firearms officers who had been involved in one or more of these contentious inquests over the timeline of 1990 to 2018 were in a position to provide a unique and less well known perspective on the contentious inquests. The lawyers who had experience of providing legal representation at these contentious inquests formed a relatively small and identifiable group. Most of these lawyers had provided legal representation at numerous of these contentious inquests and in more than one of the three periods identified.. Conducting interviews with any of these persons raised issues of ethics and confidentiality which were addressed by seeking and obtaining the approval of the ethics committee. The use of a cipher for all of those agreeing to be interviewed maintained any anonymity granted by the coroner as well the interviewee's confidentiality.[200]

3.7.1 The firearms officers[201]

Having identified the police forces concerned in the deaths that had occurred between 1990 and 2012, letters of request to interview the armed officers concerned were sent to each police force. Only two responses were received, both of which refused the request. A request sent to the Federation of Police Officers met greater success. This request was forwarded to the Police Firearms Officers Association and circulated internally among its members. In response to this request, seven firearms officers agreed to an interview. A further interview was secured via an approach made to a publisher of an account of the experiences of a former firearms officer. Interviews

[200] This was particularly relevant to the interviews with armed officers who had been granted anonymity by the coroner and which, in the absence of any court order to the contrary, effectively continued after the conclusion of the inquest.

[201] The nature and terminology of armed policing changed considerably over the timeline of this research. For the purpose of this thesis the terms 'armed police officers', 'firearms officers' and 'authorised firearms officers' are used interchangeably and are not intended to designate any particular period of armed policing.

were agreed to on the basis identities would be kept confidential and any anonymity granted by the coroner at the inquest would be preserved.

Interviews were conducted using a standardised set of (semi-open) questions and held in confidential surroundings whether this was in face to face interviews, by telephone or using video facilities. Interviews lasted no more than sixty minutes and the questions put to these interviewees were as follows.

1. What is your background as an armed police officer?
2. What (contentions) inquests have you been involved in?
3. What was the extent of that involvement?
4. For each inquest identified at Q.2 what is your opinion of
   (a) The inquest (its preparation and the final hearing)?
   (b) The other interested parties?
   (c) The coroner?
   (d) The nature of the questioning?
   (e) The verdict/conclusion?

3.7.2 The lawyers

The identity of the legal representatives who had represented the interests of the armed officers and the bereaved was identifiable from the inquest files and from media reports in the local and national press. It became apparent from these sources that a relatively small number of lawyers had appeared in numerous of these inquests. The lawyers who specialised in these contentious inquests tended to represent either the interests of the state or those of its firearms officers or otherwise the interests of the bereaved. Consequently, a small but identifiable group of lawyers demonstrated wide experience of appearing in the contentious inquests that had been held over the timeline of this research.

Numerous and often repeated requests were made to lawyers with extensive experience of representing particular interests at multiple contentious inquests, that had been held during the timeline of this research. The majority of these requests were met with no response at all despite repeated request, with a few highly experienced lawyers agreeing to take part in an interview. These interviews were held in a mixture of formats and included face-to-face, by telephone and in writing.

As with the firearms officers it was anticipated that in view of the exceptional nature of these inquests many of the details sought, were able to be recollected even where they had occurred in a much earlier period. Written requests were made to specific lawyers whose names repeatedly appeared in the inquest files and media reports of the inquests. The questions asked were the following:

1. Have you participated at any inquests in the following periods where the deceased has died as a result of a shooting by armed police officers?
    - (a) 1990 to 2000
    - (b) 2001 to 2012
    - (c) 2013 to 2018
2. Which inquest, when and what police force?
3. What was the coroner's jurisdiction for each of the inquests identified?
4. Which person(s) did you represent?
5. Did you attend any pre-inquest review hearings?
6. If yes, how many?
7. If no, what was the reason?
8. What was decided at the pre-inquest review hearings?
9. Were preparations for the final inquest hearing adequate?
10. If not, why not?
11. Did your client give evidence at the inquest?
12. What was the verdict/conclusion at the inquest?
13. Did you think this verdict/conclusion was appropriate?
14. What are your thoughts in the way the(se) inquests was/were (i) prepared for and (ii) conducted.

15. An inquest is an inquisitorial fact-finding investigation of the circumstances leading up to the death, it is not intended to be adversarial. Does this statement accord with your direct or indirect experience?
16. Please explain your answer to question number 15.
17. Were you satisfied with the outcome of the inquest?
18. Please explain your answer to question 17.
19. Is there anything you would change about the way inquests into contentious deaths are conducted? If 'yes', what?
20. Any other relevant comments.

3.8 Analysis of interviews

In the use of the case studies it is recognised that a conventional approach is the transcription of the audio recording of these interviews and analysis made using a suitable system of 'coding'. However, the interviews in this research had to be conducted by a mixture of methods that included face to face interviews, by telephone and video as well as in writing. On one occasion, three interviews had to be conducted in a confidential but unexpectedly noisy location, which did not lend itself to an effective audio recording.[202] Therefore, in order to analyse these interviews in a uniform fashion, reliance was placed on the detailed written notes taken at each interview. A further consideration was the preservation of the anonymity granted to the firearms officers by the coroner and the confidentiality requested by the firearms officers and the lawyers alike, that a 'word for word' transcription of the interview had the potential to compromise.

3.9 Coroners, the bereaved and interest groups

It is the minority of coroners, whether full-time or part-time assistants who have experience of inquests where a death has occurred as a result of a police-shooting. Considerably fewer coroners have experience of holding more than one of these contentious inquests and there are even less who have held a contentious inquest in more than one of the three periods identified in the timeline. Where a contentious

[202] Initially an interview had been arranged with a sole interviewee who unexpectedly attended with two other firearms officers. Interviews were conducted with all three interviewees to avoid the risk of them becoming unavailable at a future date.

inquest has involved the use of confidential information a High Court judge had been specifically appointed to manage and hear the inquest.[203] Since the enactment of the CJA the Chief Coroner has assumed responsibility for a number of the high profile, often terrorist related contentious inquests that were concluded in the period 2013 to 2018.

For the period 1990 to 2000 the coroners who heard these inquests were found to be long retired or otherwise unavailable. The second period of 2000 to 2012 was made up of coroners who had either long retired or although continuing in post, their experience of a police-shooting was limited to a single contentious inquest. As inquests during the period 2013 to 2018 were often ongoing or subject to continuing litigation, it was considered to be inappropriate to ask coroners to comment on their first-hand experience of these and therefore they were not approached for either, access to the inquest file or for an interview

Interviews with the bereaved who been involved in these inquests was also precluded due to the personal and sensitive nature of the subject matter and the time that had elapsed since a particular death. Research requests for interviews were not made directly to the bereaved but through interest groups with whom families were known to have contact with one group responding as follows:

> 4WardEverUK has adopted the position from 2017 that we would no longer refer requests of this type to family members that we have contact with. For the most part this is at the request of many affected families.
>
> The primary reason for this is because families frequently are approached to participate in yet more research, and generally feel that there is already a wealth of such material that already exists.
>
> Participating in such projects also means that families have to once again go over the difficult and traumatic accounts of how their loved ones died, whilst simultaneously having little confidence that another

[203] Sir Michael Wright was appointed by the coroner for Inner London South as an assistant deputy coroner for the purposes of conducting the inquest into the death of Jean Charles de Menezes. HHJ Keith Cutler was appointed by the coroner for Outer North London to be an assistant deputy coroner for the purposes of conducting the inquest into the death of Mark Duggan.

> research project will actually influence root-and-branch change in practice and policy - which is after all what they want to see.[204]

The reasons for bereaved families' reluctance to any further participation in research were expressed in the following terms:

> I'm tired of hearing the same old views expressed in research into custody deaths which re-churns statistics and historical issues within the police and judiciary institution; and which only paints the families of the victims as secondary to the facts.[205]

In view of these strongly expressed opinions on a highly personal and sensitive issue and the referral to the views of the bereaved that had previously been published, it was considered to be inappropriate to seek interviews with the bereaved as the information sought was obtainable through the original inquest files and other forms of reporting. These included the publication of 'listening days' where bereaved family members were provided with an opportunity to voice their concerns over their family member's death at the hands of the state to government committees. The family campaigns, public meetings and as well as media reports also provided sources of information from which could be ascertained, the views of the bereaved on the management of the contentious inquest in which they had become a participant.

3.10 Difficulties with data collection

The collection of the quantitative and qualitative data used for this research was not without a number of difficulties. These included:

- The sensitivity of the subject matter.

[204] Email from 4WardEverUK to author (18 June 2019).
[205] Tippa Napthall founder of 4WardEver UK, 12 February 2017.
However, in 2016, 4WardEver UK and the United Families and Friends Campaign put their support behind new research conducted by David Baker who examined custody deaths from the viewpoint of the families that are affected by them.
David Baker, '"These people are vulnerable, they aren't criminals": Mental health, the use of force and deaths after police contact in England' (2020) 93(1) The Police Journal: Theory, Practice and Principles 65.

- The identification of deceased in the fatal police-shootings
- The age of the inquests, particularly in the earliest period of 1990 to 2000.
- The ongoing nature of inquests in the later period of 2013 to 2018.
- The identification of the relevant jurisdiction where a death had occurred.
- The difficulty in obtaining permission for access to inquest files.
- The variability in the retention of the inquest files.
- The variations in the coroner's approach in the recording of these inquests and the materials retained.
- The difficulty in gaining access to firearms officers.
- The reluctance of certain groups of potential interviewees to participate in an interview.
- The need for confidentiality.

3.11 Conclusions

The sensitive, highly personal and often confidential nature of the subject matter of this research together with the localised nature of the coroner's service placed difficulties in the way of collecting both quantitative and qualitative data as previously anticipated. However, by defining the inquests for this research as those that had resulted from a fatal police shooting, this enabled inquests and participants to be identified and comparisons to be made between the different periods in the timeline. This analysis would not otherwise be possible were the contentious deaths to have included all deaths that are categorised as having occurred at the hands of the state. Unlike deaths resulting from a police shooting, inquests into other state-related deaths, did not as readily lend themselves to verdicts or conclusions of 'lawful' and 'unlawful killing' and were more likely to conclude with a critical narrative including findings of 'neglect' thereby making it problematic to make comparison and draw conclusions from inquests with few factual characteristics in common.

The identification of the police-shooting fatalities that occurred during the period 1990 to 2018 provides the factual foundation of this research. Therefore, the next chapter seeks to identify and compile a complete and verifiable record of these deaths and the inquests that followed. By using this data, access to the original inquest files could be

requested, where considered to be appropriate and information obtained for the purpose of this research.

CHAPTER FOUR: CONTENTIOUS INQUESTS 1990 to 2018

4.0 Introduction

The fatal shootings by armed police officers of civilians during the timeline of 1990 to 2018 and the inquests that were subsequently held provide the factual basis of this research. Therefore, a complete and accurate record of the deaths that makes up this category of inquests provides the secure foundation from which to conduct further research required to answer the questions posed by this thesis. It might be expected that a single and accessible official record that recorded the name of the deceased, the date and the location of their death would be maintained in view of the nature of the death and its wider importance in maintaining public confidence in the system of policing. However, it was found that a single official record of these deaths was not available.

Various official and statutorily created bodies recorded police-shooting deaths that occurred in the different periods that comprise the timeline of this research. By using a compilation of written official and unofficial sources it was possible to crossreference details of these deaths and establish their accuracy. These essential data are set out in this chapter which also records the coroner's jurisdiction where each death occurred. In addition to documenting the outcome of each inquest, this chapter records whether any criminal trial either preceded or followed the inquest and if so, the result of any such prosecution.

4.1 Identifying the fatal police shootings

In the absence of a single record of the names, dates and locations of those who had died as a result of a police shooting during the timeline of 1990 to 2018, it was necessary to cross reference information from several sources official and unofficial sources in order to test the veracity, reliability and accuracy of these data.

The information that appears in Table 1 was compiled using official sources from the Home Office,[206] the annual reports of the PCA, information provided under the Freedom of Information Act 2000 by the IPCC[207] as well as the unofficial records of the leading interest group INQUEST.[208] The information as to fatal police shootings kept by the PCA in its annual and other reports provided the number of deaths and their dates but tended to anonymise the names of those who had died, even when providing details about the circumstances of the death. Information obtained from the IPCC was more detailed, although its records began in 2004 being the date on which it had assumed the responsibilities of the PCA. The records of the IPCC provided the names, dates and locations of the fatal shootings of civilians from 2004 to 2018. However, the IPCC records excluded the death of Dorothy Groce, as the shooting injury that had contributed to her 2011 death had taken place in 1985 and had been investigated by the PCA at that time.

Other unofficial sources of information used to verify the names and dates of the deceased included published accounts from former firearms officers[209] and other publications on the history of firearms and armed police in the UK.[210] From these, it was possible to cross-reference the firearms officers' accounts with the limited records of the PCA for the purposes of verifying these essential data. These accounts often provided useful corroborating details about many of these fatal shootings that occurred in the period 1990 to 2000, including the name of the deceased, the date and location of the police-shooting death, the date of the final hearing and the outcome of the

[206] In response to an email request from the author under the Freedom of Information Act 2000 (reference: 54742), the Home Office, Crime, Policing and Fire Group confirmed it held some of the information requests regarding the names, dates and locations of those fatally shot by armed police officers during the period 1990 to 2018 and provided a copy of this information.

[207] The IPCC confirmed and provided the list of those who had died as a result of a shooting by armed police officers during the period 2004 and 2018.

[208] INQUEST, 'Fatal Police Shootings (England & Wales) 1990-date.' INQUEST's figures are derived from their ow monitoring and casework and are independent of those produced by the Home Office and other government agencies.

<w*ww.inquest.org.uk › fatal-police-shootings*> accessed 20 September 2020.

[209] Stephen Smith, *Stop! Armed Police! Inside the Met's Firearms Unit,* (Robert Hale 2013). See also, Tony Long, *Lethal Force (*Ebury Press 2016).

[210] Peter Squires and Peter Kennison, *'Shooting to kill? Policing, Policing, Firearms and Armed Response,* (John Wiley & Sons Ltd 2010) 22, 30.

inquest. The difficulties of obtaining a complete and verifiable set of data were highlighted by another publication which purported to include the names and year of

those who had died as a result of a police shooting this timeline omitted a number of names that appear in Table 1.[211]

4.2 An anomaly in the records of fatal police shootings

Although the various official and unofficial sources that were consulted were largely corroborative, one record did produce an unexpected anomaly. This irregularity occurred with the recording of the death of Keith Carrot. In a written answer provided by the Home Office to the House of Commons detailing the names of those who had died in 1991 and 1992, it was recorded in the official parliamentary record that the death of Keith Carrott had occurred on 10 December 1991.[212] In seeking to cross reference this account of Keith Carrott's death, it was discovered that Hansard appeared to be the only official source that recorded this fatal shooting as an independent corroborating record of Keith Carrott's death could not be found. A request to the General Registry Office for a copy of a death certificate for Mr Carrott also proved to be unsuccessful.[213]

INQUEST has regularly published an unofficial but well-regarded source of data that have covered the period 1990 to 2018. These records have included the names of those who had died, the date and location of the police shooting and included the outcome of the subsequent inquest.[214] Although INQUEST included Keith Carrott's death in its statistics and ascribed to it an inquest verdict of lawful killing, it was unable to provide any further information as to where Keith Carrott's death had occurred or where the inquest had been held or explain how it had been able to record this

[211] Peter Squires & Peter Kennison, *Shooting to Kill? Policing, Firearms and Armed Response* (John Wiley & Sons 2010) 23, 26.

[212] HC Deb 22 October 1992 vol 212 cc 381–2 W.

[213] The General Registry Office provides copies of death certificates on request and on payment of a fee.

[214] INQUEST's figures are said by it to be derived from our monitoring and casework and are independent of those produced by the Home Office, the Independent Office for Police Conduct (IOPC) and other government agencies but record 9 nine deaths for the period 1991 to 1993. <www.inquests.org.uk>fatal-police-shootings> accessed 14 July 2020.

verdict.[215] Further, no national or local newspapers appeared to carry any record of Keith Carrott's death during the timeline of 1990 to 2018.

Further research into this anomaly revealed that an explanation appears to lie in the records and reports of the PCA. In its 1993 report, the PCA conducted a review of the discharge of firearms by police in England and Wales during the period 1991 to 1993.[216] Although this review was unpublished and unavailable for this research, a reference to this review was made in the PCA's 2003 review of shootings by police in England and Wales from 1998 to 2001.[217] This 2003 report stated the following:

> The report follows a previous (unpublished) report examining the discharge of firearms by police between 1991 and 1993, known as the 'Burrows Report' (ACPO in consultation with the PCA), which reviewed a total of 23 incidents referred to the PCA (eight of which were fatal).[218]

Table 1 illustrates that there were eight verified fatal police shootings in the period 1991 to 1993. Therefore, it appears likely that the reporting of Keith Carrott's death as the result of a police shooting has been an error although the source of this is unknown.[248] This apparent error has been repeated in other unofficial records of deaths that have resulted from a police shooting.[219] Consequently, for the purposes of this research the reported death of Keith Carrott is treated with caution as no other details as to the circumstances of his death and the subsequent inquest have been located.

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[215] In email correspondence between the author and INQUEST on 24 May 2019 a response was received which stated, 'I have had a look for information on the death of Keith Carrott, and unfortunately all I can find is his name on our statistics database of all deaths in police custody. The date of death matches the one you have, and the only other column that is full is that of the inquest conclusion, which was a
[216] Joint Standing Committee on the Police Use of Firearms in consultation with the PCA (unpublished). 'A Review of the Discharge of Firearms by Police in England and Wales 1991–1993' (unpublished) ('The Burrows Report'). Although this document may have verified whether the fatal shooting of Keith Carrott occurred it was not made available, although the College of Policing confirmed it held a copy of the document in email correspondence with the author dated 1/8/10 and 27/8/19.
[217] The College of Policing acknowledged that it retained a copy of this report but declined to disclose it on security grounds.
[218] Police Complaints Authority, 'Review of shootings by police in England and Wales from 1998 to (HC 313, 2001)< library.college.police.uk>pca-firearms-report-2003> accessed 20 October 2020. [248] The Metropolitan Police Service could confirm that it had no record of Keith Carrott's death as having occurred in its jurisdiction or otherwise or as a result of one of its officer's actions.
[219] These included the records kept by INQUEST although it openly states it does not rely on official records for its data but uses on its own case monitoring from which it produces its records of fatal police shootings.

verdict of Lawful Killing. It appears that we did not work with the family on this case, so do not have anything further.'

Table 1: Fatal shootings by armed police officers 1990 to 2018

No.	Name and year of death	Coroner's region or area [220]
1.	Michael Alexander - 1990	West London
2.	Kenneth Baker - 1990	Surrey
3.	Ian (Garfield) Gordon - 1991[221]	Shropshire, Telford & Wrekin
4.	Derek Wallbanks - 1991	Newcastle upon Tyne
5.	Keith Carrott - 1991[252]	Unknown
6.	Ian Bennett - 1992	West Yorkshire (Western)
7.	Barry Clutterham −1992	Suffolk
8.	Peter Swann - 1992	South London
9.	David Luckhurst - 1993	Hertfordshire
10.	Ian Hay - 1993	Plymouth, Torbay and South
11.	David Stone - 1993	Inner North London
12.	John O'Brien - 1994	Inner North London
13.	Robert Dixon - 1994	West Yorkshire (Western)
14.	David Ewin - 1995	Inner West London
15.	James Brady - 1995	Newcastle upon Tyne
16.	Diarmund O'Neill - 1996	West London
17.	David Howell - 1996	Birmingham and Solihull
18.	James Ashley −1998	East Sussex
19.	Michael Fitzgerald - 1998	Bedfordshire and Luton
20.	Anthony Kitts - 1999	Cornwall and the Isles of Scilly
21.	Derek Bateman - 1999	Surrey
22.	Harry Stanley - 1999	Inner North London
23.	Kirk Davies - 2000	West Yorkshire (Eastern)

[220] The coroner's jurisdictions are as designated in the Report of the Chief Coroner to the Lord Chancellor, Fifth Annual Report: 2017–2018, Annex C.
<www.gov.uk/government/publications> accessed 14 May 2020.

[221] HC Deb 22 October 1992 vol 212 cc 381–2 W. In this Hansard record Mr. Gordan is recorded as Ian Garfield, with the death of Ian Gordon appearing to be separately recorded. This recording is incorrect as verified by the original inquest file. However, for the avoidance of any further confusion, Mr Gordan is throughout this research referred to as Ian Garfield Gordan. [252] This entry is uncorroborated.

No.	Name and year of death	Coroner’s region or area [250]
24.	Pa trick (Kieron) O’Donnell - 2000	Inner North London
25.	Steven Dickson - 2001	Derby and Derbyshire
26.	Michael Malsbury - 2001	North London
27.	Derek Bennett - 2001	Inner South London
28.	Andrew Kernan - 2001	Liverpool and the Wirral
29.	Jason Gifford - 2001	Buckinghamshire
30.	Fosta Thompson - 2002	Avon
31.	Colin O’Connor - 2003	Bedfordshire and Luton
32.	Keith Larkins - 2003	West London
33.	Philip Prout - 2004	Plymouth, Torbay & South Devon
34.	Nicholas Palmer - 2004	South London
35.	Simon Murden - 2005	East Riding and Hull
36.	Azelle Rodney - 2005	North London
37.	John Scott - 2005	South Northumberland
38.	Jean Charles de Menezes - 2005	Inner South London
39.	Craig King - 2005	Manchester South
40.	Phillip Marsden - 2005	Staffordshi re South
41.	Robert Haines - 2006	Central and South East Kent
42.	Terry Nicholas - 2007	West London
43.	Ann Sanderson - 2007	North West Kent
44.	Mark Nunes - 2007	Wiltshire and Swindon
45.	Andrew Markland – 2007	Wiltshire and Swindon
46.	Daynie l Tucker - 2007	North West Kent
47.	Mark Saunders - 2008	Inner West London
48.	Andrew Hammond - 2008	East London
49.	David Sycamore	Surrey
50.	Mervyn Tussler - 2009	West Sussex
51.	Keith Richards - 2009	County Durham & Darlington
52.	Alistair Bell – 2010	West Yorkshire (Western)
53.	Michael Fitzpatrick – 2011	Brighton and Hove
54.	Dorothy (Cherry) Groce - 2011[222]	Inner South London
55.	Mark Duggan - 2011	North London
56.	Anthony Grainger - 2012	Manchester South
57.	Dean Joseph - 2014	Inner North London
58.	James Fox - 2015	North London
59.	Richard Davies - 2015	Cambridgeshire and Peterborough

[222] The death of Mrs Groce is included in statistics recorded by INQUEST and other interest groups. However, the IPCC excludes Mrs Groce’s death in its own statistics as she was shot during an armed police operation in 1985 from which she was left paralysed contributing to her death in 2011.

60.	Jermaine Baker - 2015	North London
61.	James Wilson - 2016	Newcastle upon Tyne
62.	William Smith - 2016	North West Kent
63.	Josh Pitt - 2016	Bedfordshire and Luton
64.	Lewis Skelton - 2016	East Riding and Hull
65.	Yasser Yaqub - 2017	West Yorkshire (Western)
66.	Khalid Massod - 2017	Inner West London
67.	Khuram Butt - 2017	Inner South London
68.	Rasheed Redouane - 2017	Inner South London
69.	Zaghba Youssef - 2017	Inner South London
70.	Spencer Ashworth - 2017	Avon
71.	Richard Cottier - 2018	East London

4.3 Inquests, verdicts and conclusions

In collecting these data, it was necessary to use the same range of resources for the purposes of Table 2 as have been identified for the data collection for Table 1 as no single official record providing this information was available.

Table 2: Contentious inquests 1990 to 2018

No.	Name of deceased	Year of inquest	Outcome of inquest	Criminal trial	Outcome
1.	Michael Alexander	1991	Lawful killing	No	N/A
2.	Kenneth Baker	1991	Lawful killing	No	N/A
3.	Ian Garfield	1992	Lawful Killing	No	N/A
4.	Derek Wallbanks	1992	Lawful killing	No	N/A
5.	Keith Carrott	1992	Lawful killing	No	N/A
6.	Ian Bennett	1992	Lawful killing	No	N/A
7.	Barry Clutterham	1992	Lawful killing	No	N/A
8.	Peter Swann	1992	Lawful killing	No	N/A

9.	David Luckhurst	1994	Lawful killing	No	N/A
10.	Ian Hay	1994	Lawful killing	No	N/A
11.	David Stone	1994	Lawful killing	No	N/A
12.	Robert Dixon	1995	Lawful killing	No	N/A
13.	John O'Brien	1995	Lawful killing	No	N/A
14.	David Ewin	Inquest not resumed	N/A	Yes	Acquitted of manslaughter
15.	David Howell	1997	Lawful killing	No	N/A
16.	James Brady	1998	Open	No	N/A
17.	James Ashley	Inquest not resumed	N/A	Yes	Trial halted by judge
18.	Michael Fitzgerald	1998	Lawful killing	No	N/A
19.	Derek Bateman	1999	Lawful killing	No	N/A
20.	Diarmuid O'Neil	2000	Lawful killing	No	N/A
21.	Anthony Kitt s	2000	Lawful killing	No	N/A
22.	Steven Dickson	2002	Lawful killing	No	N/A
23.	Patrick (Kieron) O'Donnell	2002	Lawful killing	No	N/A
24.	Kirk Davies	2002	Lawful killing	No	N/A
25.	Michael Malsbury	2003	Suicide (by cop)	No	N/A

[254] INQUEST records the outcome of Keith Carrott's death as 'lawful killing' although this is not independently recorded elsewhere.

No.	**Name of deceased**	**Year of inquest**	**Outcome of inquest**	**Criminal trial**	**Outcome**
26.	Derek Bennett	2004	Lawful killing	No	N/A
27.	Andrew Kernan	2004	Lawful killing	No	N/A
28.	Jason Gifford	2004	Suicide (by cop)	No	N/A
29.	Colin O'Connor	2005	Lawful killing	No	N/A
30.	Philip Prout	2005	Lawful killing	No	N/A
31.	Fosta Thompson	2005	Lawful killing	No	N/A
32.	Keith Larkins	2005	Lawful Killing	No	N/A
33.	Harry Stanley	2005	Open	No	N/A

34.	Nicholas Palmer	2005	Lawful killing	No	N/A
35.	Craig King	2006	Lawful killing	No	N/A
36.	John Mark Scott	2007	Lawful killing	No	N/A
37.	Phillip Marsden	2008	Lawful killing	No	N/A
38.	Simon Murden	2008	Lawful killing	No	N/A
39.	Jean Charles de Menezes	2009	Open	No	N/A
40.	David Sycamore	2009	Lawful killing	No	N/A
41.	Terry Nicholas	2009	Lawful killing	No	N/A
42.	Robert Ha ines	2010	Lawful killing	No	N/A
43.	Mark Saunders	2010	Lawful killing	No	N/A
44.	Ann Sanderson	2010	Lawful killing	No	N/A
45.	Mervyn Tussler	2010	Lawful killing	No	N/A
46.	Dayniel Tucker	2010	Lawful killing	No	N/A
47.	Andrew Hammond	2010	Lawful killing	No	N/A
48.	Keith Richards	2011	Lawful killing	No	N/A
49.	Mark Nunes	2011	Lawful killing	No	N/A
50.	Andrew Markland	2011	Lawful killing	No	N/A
51.	Michael Fitzpatrick	2012	Lawful killing	No	N/A
52.	Alistair Bell	2014	Narrative (justified shooting)	No	N/A
53.	Mark Duggan	2014	Lawful killing	No	N/A
54.	Dorothy (Cherry) Groce[223]	2014	Critical narrative	Yes	1987- officer acquitted of assault charges

[223] On 28 September 1985, during a search of her home for her son, who was wanted for questioning regarding an earlier incident that had occurred elsewhere, Mrs Groce was shot and rendered paraplegic by an armed officer. Although Mrs Groce did not die until 24th April 2011, the pathologist who performed the autopsy linked her cause of death to paralysis caused by the firearms officer. Therefore,

No.	Name of deceased	Year of inquest	Outcome of inquest	Criminal trial	Outcome
55.	Dean Joseph	2015	Lawful killing	No	N/A
56.	James Fox	2016	Lawful killing	No	N/A
57.	Richard Davies	2017	Lawful killing	No	N/A
58.	James Wilson	2018	Lawful killing	No	N/A
59.	William Smith	TBD	Pending	?	?
60.	Josh Pitt	2019	Lawful killing	No	N/A
61.	Lewis Skelton	TBD	Pending	?	?
62.	Yasser Yaqub	TBD	Pending	?	?
63.	Khalid Masood	2018	Lawful killing	No	N/A
64.	Khuram Butt	2019	Lawful killing	No	N/A
65.	Rasheed Redouane	2019	Lawful killing	No	N/A
66.	Zaghba Youssef	2019	Lawful killing	No	N/A
67.	Spencer Ashworth	2020	Lawful killing	No	N/A
68.	Richard Cottier	TBD	Pending	?	?

Of the sixty-eight deaths shown in Table 2, sixty-two have resulted in concluded inquests with two inquests not resumed after unsuccessful criminal prosecutions, four inquests are still to be concluded by a final hearing and three of the seventy-one inquests shown in Table 1 were converted to a public inquiry.[256] Of the sixty-two inquests concluded, none resulted in a determination of unlawful killing although one inquest resulted in a narrative verdict critical of the police operation. Three inquests concluded with an open verdict in an indication that the jury was not persuaded by the evidence that the deceased had been lawfully killed but were unable to reach a verdict or conclusion of unlawful killing. In two of these inquests the jury concluded with the unusual verdict of 'suicide by cop.'[224] Of the remaining inquests, fifty-five concluded with a verdict or conclusion of 'lawful killing' and one recorded a narrative verdict of a justified killing.

[224] News Shopper, 'Suicide by cop' verdict condemned' (15 May 2003) <www.newsshopper.co.uknews>6247813.suicide-by-.. . .> accessed 13 July 2020. In criticising this verdict Deborah Coles of INQUEST said: "This is a perverse verdict and an extremely dangerous precedent, an attempt to distract attention from the lawfulness of the police use of firearms.

as an Article 2 duty was engaged a jury inquest was held, the ambit of which included the planning and performance of the police operation on the night of her shooting. [256] This includes the unverified death and inquest of Keith Carrott.

The data recorded in Table 2 illustrates that regardless of the date of the death or the inquest, there have been few criminal prosecutions of firearms officers either immediately after the inquest has been opened by the coroner or after it has concluded. On the three occasions where criminal prosecutions have resulted after a policeshooting none have resulted in a successful criminal prosecution.[225]

4.4 The contentious inquests converted to a public inquiry

In order to provide a complete account of the seventy-one fatal shootings that form the basis of this research, Table 3 sets out details of those inquests that were adjourned by the coroner with the investigation into the death having been concluded by way of a public inquiry under the provisions of the Inquiries Act 2005.[226] The first of these inquests concerned the fatal shooting of Azelle Rodney, where a public inquiry was determined to be necessary to satisfy the state's Article 2 obligation to conduct an investigation. The evidence relevant to this inquest included material collected under the Regulation of Investigatory Powers Act (RIPA) provisions to which access was not permitted to the coroner and as a result of which it was decided that an Article 2 compliant inquest could not be held.[227] The public inquiry concluded with a finding of 'unlawful killing' and the firearms officer concerned was prosecuted on a charge of murder of which he was subsequently acquitted.[228]

The second inquest that was converted to a public inquiry concerned the death of Anthony Grainger. In that instance, a public inquiry was deemed necessary as it was decided that it was not possible to share with a jury certain sensitive information the

[225] This figure includes the two immediate fatalities of James Ashley and David Ewin and the 1985 wounding of Dorothy Groce which did not lead to her death until 2011.

[226] Coroners Act 1988, s 17A and Coroners and Justice Act 2009, sch 1 para 4 make provision for adjourning the inquest and completion of the investigation by public inquiry.

[227] Regulation of Investigatory Powers Act 2000. This provides that certain evidence (including intercept information) can only be disclosed to a High Court Judge or above which prohibits its disclosure to a coroner.

[228] Tony Long, Lethal Force (Ebury Press 2016)

coroner deemed central to the ambit of the inquest.[229] Although the public inquiry concluded with a finding of 'lawful killing' further consideration is being given to a

criminal prosecution. The third public inquiry concerns the death of Jermaine Baker and is yet to be held.[230]

Table 3: Inquests converted to a public inquiry

No.	Name	(i) Year of Death (ii) Year of Inquiry	Outcome	Criminal trial	Outcome
1.	Azelle Rodney	(i) 2007 (ii) 2013	Unlawful killing	Yes	Firearms officer acquitted of murder
2.	Anthony Grainger	(i) 2012 (ii) 2019	Lawful killing (Report critical of police)	Being considered	N/A
3.	Jermaine Baker	(i) 2015 (ii) To be held	To be determined	To be determined	To be determined

4.5 Analysis

From the data contained in Table 1 and Table 2 it has been demonstrated that despite the coroner's jurisdiction, the date of the police-shooting or the engagement of Article 2 to these inquests, none have resulted in a verdict or conclusion of 'unlawful killing'. In the few instances where criminal prosecutions have followed a police-shooting they have all failed to result in a conviction. It is strongly suggested by the protests and the family campaigns of the bereaved and their supporters that the accountability sought

[229] Home Office, The Anthony Grainger Inquiry: Report into the Death of Anthony Grainger Chairman: (HC2354, 2019) This inquiry was chaired by HHJ Teague QC. < www.gov.uk/official-documents> accessed 20 June 2020.

[230] The converting of the inquest of Jermaine Baker was announced by the Home Secretary on 12th February 2020 for the purpose of allowing all the facts to be considered. <www.gov.uk › Crime, justice and law> accessed 20 June 2020.

by them cannot be provided by the inquest but only in the forum of the criminal courts and that the therapeutic or restorative justice referred to in the literature is insufficient.[231] The accountability on the part of the State and its agents sought by the

bereaved in family campaigns and interest groups as a criminal prosecution and conviction and is an ongoing concern vocalised by the Black Lives Matter movement.

4.6 Conclusions

The data recorded in Tables 1 to 3 identify the seventy-one civilian deaths that resulted from a shooting by police firearms officers in thirty-five coroner's jurisdictions and the outcomes of the inquests that followed in the nineteen year timeline of inquests held during 1990 to 2018. The difficulties encountered in compiling this information required a wide range of official and unofficial sources to be consulted to ensure a complete and accurate record of these data were recorded. It was unexpected to find anomalies in the records of deaths that had resulted from a police shooting considering the gravity of the events they recorded, their impact on the bereaved and the possible consequences that arose for the firearms officers and their police employer.

It was significant to observe that nearly all of these inquests had resulted in a verdict or conclusion of lawful killing, despite the variation of coroner's jurisdictions concerned with these inquests and the period over which these inquests were concluded. It was also of relevance to find that none of the inquest juries had concluded their determinations with an outcome of 'unlawful killing' and the two inquests adjourned pending the prosecution of a firearms officer had been unsuccessful in securing a conviction. These outcomes seemingly failed to provide 'justice' for the bereaved by either a public recognition of their loss or a pathway to securing retributive justice and accountability in the criminal courts.

[231] The family campaigns and protests established after the deaths of Derek Bennett, Diarmuid O'Neil, Harry Stanley, Jean Charles de Menezes and Mark Duggan all indicate that 'justice' for the bereaved equates to a criminal prosecution and conviction and is a theme echoed in the increasingly vocal Black Lives Matter movement.

Although these data provide an important factual foundation for this research, they are not in isolation able to demonstrate the impact of the significant developments that had occurred during 1990 to 2018 in the coronial forum. Consequently, it is not possible to establish from these data whether these contentious inquests had acquired any adversarial features during the timeline of this research and if so, the reasons for this. Therefore, to answer the questions raised in this thesis, a greater in-depth study of the concluded contentious inquests is required to identify any patterns of similarities and differences arising from them during the three periods identified during the timeline of 1990 to 2018. It is anticipated that further scrutiny of these inquests may demonstrate whether any changes to the contentious inquests could be correlated with and attributed to the substantive legal and procedural requirements that the HRA's Article 2 brought to the inquest forum and which were placed on a statutory footing by the modernising legislation of the CJA.

The identification of similarities and differences in the inquests that were concluded between 1990 and 2018 requires each of the three time periods to be considered individually. Therefore, the next chapter investigates in more depth the inquests that were held under the now repealed and replaced 1980's coroner's legislation during the first period of 1990 to 2000 with the use of original file material and other official and unofficial publication in order to compile detailed information about these contentious inquests.

CHAPTER FIVE: THE CONTENTOUS INQUESTS 1990 TO 2000

5.0 Introduction

During the period 1990 to 2000, twenty-four deaths resulted from a shooting by police firearms officers from various police authorities. These deaths took place in fifteen coroner's regions with the jurisdiction of one death remaining unknown.[232] Although all of these deaths were the subject of an inquest, only seventeen of these were concluded during this period.[266] The coroner did not resume the inquests of David Ewin[233] and James Ashley[234] that were adjourned after the initial openings, as the criminal prosecution of the firearms officers, albeit unsuccessful, were decided to have satisfied the investigative duty of the state. Of the seventeen remaining inquests, only sixteen have been verified as having taken place during this period or at all, with the other five remaining inquests being held during the second of the periods identified in the timeline.[235]

This chapter explores in greater depth all of the sixteen verified inquests that were concluded under the 1980's coronial legislation during the period 1990 to 2000, which the automatic engagement of its Article 2 to the investigations and inquests into these fatal police-shootings, These sixteen inquests provide a benchmark against which the inquests held in the two later periods can be compared. Although the investigative requirements of Article 2 had not been implemented into domestic coronial law during

[232] See Table 1. [266]
See Table 1.
[233] Mike Waldren, *The Police Use of Firearms since 1945* (Sutton Publishing Ltd 2007) pp 201, 203. After the shooting of David Ewin, a total of three criminal trials were brought against the officer responsible for firing the fatal shot. These resulted in a mistrial, the dismissal of the jury for failing to reach a verdict and finally an acquittal.
[234] *Ashley (Fc and Another (Fc) v Chief Constable of Sussex Police* [2008] UKHL 25. The judge in the trial of the officer whose shot had killed Mr Ashley was acquitted on the judge's direction after a submission of 'no case to answer.'
[235] Although INQUEST provides a verdict of 'lawful killing' to the inquest of Keith Carrott this outcome has not been able to be corroborated from any other source as the location in which Mr Carrott died is unknown.

this period, the coroner was nevertheless required 'To ensure that the relevant facts are fully, fairly and fearlessly investigated.'[236]

A reliable source of information regarding how each of these inquests was dealt with by the coroner lay in the original inquest files and access to this material was sought from each senior coroner in whose jurisdiction the inquest had been held. Where an inquest had been concluded over fifteen years ago, it could not be assumed that the file would continue to be outside the statutory period mandated for the coroner's retention of the inquest materials.[237] A further factor that had to be taken into consideration regarding these older inquests, was the requirement of ensuring that the request for access to the file was made to the senior coroner in the correct jurisdiction in which the inquest had been held.

Due to the amalgamation of many coroner's regions into larger coroner's areas after the enactment of the CJA, it was necessary to ascertain whether the coroner's court that had held the inquest, remained in the same jurisdiction as previously, or whether it had been amalgamated with another region and if so, the identity of that new jurisdiction. The Coroner's Society of England and Wales was a useful source of information as to the current coroners' areas and each local authority website provided details as to the neighbourhoods that were included in its coronial jurisdiction. The use of electronic databases in the coroner's courts proved useful when seeking confirmation from coroner's officers or administrative staff, that a particular inquest had been heard within that jurisdiction and if so, whether the original file continued to be retained and its storage location. Where the file was not available, due to it either having no longer been retained or the senior coroner had refused access,[238] other

[236] *R (Jamieson) v HM Coroner for North Humberside and Scunthorpe* [1995] 1 QB 1, 26 (Sir Thomas Bingham MR).

[237] The Coroners Rules 1984, r 56. A coroner must retain documents in connection with an investigation or post-mortem examination for 15 years.

[238] The views of coroners about whether an inquest file should be permitted to be accessed for this research ranged from unconditional permission being given on the basis that the inquest was a public matter and therefore the material should be open to access, to outright refusals on the grounds of confidentiality and the position of permission being granted subject to the confidentiality of certain materials being maintained. The Coroners Rules 1984 r 57 provided the coroner with a wide discretion as to who might be considered a 'properly interested person' for reason of inspection of the documents. Similarly, the Coroners (Investigations) Regulations 2013 reg 27 provides the coroner with a discretion as to who is a 'proper person' to be provided with or a copy of inquest documents.

sources of information had to be utilised. These sources included case law reports, media reports, press releases from interest groups and family campaigns as well as publications by former firearms officers.

By using a standardised set of questions when reviewing the file materials in place of interviews with the bereaved, it became apparent how the inquest had been managed by the coroner. Where the original file was not available, the information sought for the purpose of making comparisons between the inquests, had to be confined to the date of death, the date of the final hearing and the time taken to conclude it. These particular details were likely to be ascertainable from other published sources and collectively would provide the information against which the later inquests could be measured.

5.1 The inquest files

The original inquest file material provided an important primary source of information as they revealed details about the approach adopted by the coroner in the management of the inquest. This information included the coroner's decisions on the ambit of the inquest, the holding of preliminary hearings, which witnesses were required to give oral evidence and which statements could be read in court, the grant or refusal of anonymity to the firearms officers, the use of independent expert, the disclosure of the documentary evidence to interested parties and the date, location and time estimate of the final hearing. The file material also provided information as to the verdicts the interested parties had called for the coroner to leave to the jury to consider in its decision making.

The responses of senior coroners to request for access to files reinforced the difficulties of carrying out research in this subject area and ranged from an outright refusal to an unconditional grant of access and most often, no response at all. Where access to files was granted it was on the understanding that the anonymity of firearms officers would

be maintained and the confidentiality of information that would not have been known at the time of the inquest would continue to be respected.[239]

The local nature of the coroner's service and the individual approach adopted towards record keeping during the 1990's created unpredictability as to the nature and extent of the inquest materials retained by any particular coroner's jurisdiction and even varied considerably within the same jurisdiction. The completeness or otherwise of the contents of these inquest files from this period depended upon a combination of factors that included the date of the inquest and its final hearing, the importance of the inquest, the storage facilities provided to the coroner and interpretation of the legislative requirements for such file retention.

Original materials from seven contentious inquest that were concluded in this period were reviewed although the contents of each file varied significantly. Few of these files contained a complete typed transcript of the evidence heard at the final hearing although all of these materials included a copy of the official record of the inquest. This record was in the form of inquisition required to be signed by the members of the jury and the coroner at the conclusion of the inquest and recorded the jury's answers to the four core questions of 'who, when, where and how' together with other findings they had made that were deemed of sufficient importance to record. Frequently, these files also contained photographs, maps and plans of the area in which the death had occurred and the handwritten notes of the proceedings kept by the coroner. The extent of the documentation contained in each of these files varied considerably with several files being particularly limited in the information it contained, despite the requirement that all documents in connection to the inquest should be retained. The files, however sparse the materials they contained, nevertheless were able to provide information regarding the date of the final hearing, the period over which it was held and the outcome of the inquest.

Where permission to access these files had been granted by the senior coroner all inspections of these materials took place on a pre-arranged date and were viewed in

[239] See Appendix 3 for a table of the requests made to and the responses received from senior coroners.

situ at the coroner's court building located in the jurisdiction in which each inquest had been held. This form of arrangement was required due to the necessity of having first to retrieve the file from its place of storage, the confidential nature of the contents of each file which were not permitted to be removed from the court building and the lack of physical space in which to accommodate visitors in otherwise busy coroner's court buildings.

Although 1980's coroner legislation made no provision for the holding of preliminary hearings or the pre inquest disclosure of evidence, the coroner was not statutorily prohibited from making provision for either of these steps. Therefore, the preparatory steps required in order for a full and effective inquest to be held remained subject to the exercise of the coroner's wide-ranging discretionary powers.[240] The following seven case studies have been compiled from a review of the original inquest file material to which access was permitted by the senior coroner in the jurisdiction in which each file had been retained.

By utilising a standardised set of questions for each file accessed, the similarities and differences in the coroner's management of these inquests provided a basis from which comparisons between the inquests could be drawn and analysis made, despite the differences in the extent of the documents retained and the information each file provided. These case studies also provided an illustration of the way these preparatory issues and exercise of the coroner's discretionary powers impacted upon the management of the inquest and the extent of involvement the interested parties, particularly the bereaved, were afforded during this period of inquests.

In considering the material provided in the inquest files, it became clear that the issue of whether a witness had been warned of the possibility of self-incrimination was likely only to be evident from the full transcript of the final hearings. As the availability of these transcripts in the inquest files was significantly limited, this question was

[240] Some coroners took the view that documents belonging to the police force concerned were confidential and therefore could not be disclosed to the bereaved. However, in *Peach v Commissioner of Police of the Metropolis*: [1986] QB 1064 the court determined that the coroner should be provided with all statements prepared in the course of the investigation into the death to facilitate the inquest and enable the coroner to determine which witnesses were required.

subsequently omitted from the questions that were used as a template by which to interrogate the inquest files.

5.2 Case studies

The following case studies are taken from the material available in the original inquest materials. The information sought from each reviewed file comprised matters that would have been in the public arena at the date the inquests were held as the coroner was required to conduct these hearings in public and included the following:[241]

1. The identity and number of Properly Interested Persons (PIPs) or Interested Parties (IPs).

2. The ambit of the inquest.

3. If IPs or PIPs were legally represented?

4. The number of witnesses (oral & documentary) called to give oral evidence or gave "read" evidence.

5. If Rule 22 (right not to incriminate yourself) was utilised?[242]

6. Other evidence used at the inquest e.g. CCTV, surveillance footage.

7. The number of pre-inquest review hearings (PIRH) held in preparation for the inquest.

8. Pre-inquest disclosure – what and to whom given and when?

9. Legal questions arising at both the preliminary stages and the substantive inquest, e.g. application for Public Interest Immunity, anonymity of witnesses.

10. The submissions by PIPs/IPs as to the verdicts or conclusions that can be left to the jury.

11. The time taken to hear the inquest.

[241] Coroners Rules 1984 r 17; Coroners (Inquests) Rule 2013 r 11. Any confidential material that was also included in the file materials but not publicly made known has not been referred to in the case studies.
[242] This question had to be subsequently discarded as an answer to this question proved to be unavailable from the preparatory documents or coroner's notes and full transcripts of the evidence heard during the final hearing , which would provide the answer were frequently unavailable.

12. Whether there was a Prevention of Future Deaths Report following the conclusion of the inquest?

Each case study has included a degree of background information as to the unique circumstances in which each of these fatal shootings occurred. This information has been included to aid an understanding of the singular nature of each of these inquests in this unique forum, while seeking to identify common themes and concerns for the purpose of answering the questions posed in this chapter.

5.2.1 Michael Alexander [243]

Armed police firearms officers from the Metropolitan Police Service (MPS) fatally shot Michael Alexander on 26th April 1990 in the course of an armed robbery on a sub Post Office in Brentford while in the company of two accomplices.[244] The coroner recognised the bereaved family, the Commissioner for the MPS and three firearms officers as interested parties. The ambit of the inquest that was held at the West London Coroner's Court concerned the armed operation itself, an investigation of the use of firearms and the background of 'Operation Magdelena' which had been set up by the police force, in answer to a series of these robberies that had been happening in the area. Pre-inquest disclosure of evidence took place between the police force and the coroner in which the bereaved family members appear not to have been involved in the absence of correspondence with them in the file materials. The issue of anonymity for a police informant was discussed between the coroner and the police representatives with no oral preliminary inquest hearings being held as all preliminary matters were dealt with in correspondence.[245]

[243] The original inquest file of Michael Alexander was accessed on 6 December 2018 at a secure offsite location used by West London Coroner's Court.

[244] Stephen Smith, *Stop! Armed Police! Inside the Met's Firearms Unit* (Robert Hale 2016). The two accomplices subsequently pleaded guilty at the Old Bailey in December 1990.

[245] The inquest file for Mr Alexander revealed no correspondence from the coroner with bereaved family members. However, this is not conclusive of whether any such correspondence took place, as the same documents on any inquest file have not always been retained.

Of the interested parties recognised by the coroner, the police force and the individual officers were legally represented, while the family of the deceased was not. During the final hearing, the jury considered oral and written evidence of seventy witnesses in addition to going on a site visit to the scene of the shooting during a final hearing, which lasted for five days. The inquest concluded with the jury reaching a verdict of 'lawful killing.' Although family members had requested the coroner to leave a verdict of unlawful killing to the jury to consider, this outcome was not considered to be appropriate on the evidence heard and therefore the jury was not permitted to consider such a verdict. At the conclusion of the inquest the coroner did not consider that a Prevention of Future Deaths Report was necessary.

5.2.2 Ian Garfield Gordon [246]

On 12th August 1991, Ian Garfield Gordon was fatally shot by armed police from the West Mercia Constabulary after brandishing a gun at a train station that was subsequently discovered to be an inoperative air gun. The Police Complaints Authority requested Merseyside Police to conduct an investigation into the shooting, which had sparked public unrest in the area. The interested parties comprised the family of Mr Gordon, the Chief Constable of the West Mercia Constabulary and the individual officers involved in the fatal shooting all of whom were legally represented.

The inquest was held at the Shrewsbury Coroner's Court and the ambit of the inquest concerned the immediate circumstances of the shooting by the firearms officers with some consideration being given to issues of the mental health of Mr. Gordan as well as the principles of using arms and the armed response training of police officers. The coroner did not hold any pre-inquest review hearings and preparation for the inquest was dealt with in correspondence between the coroner and the interested parties. These included legal issues concerning the application for public interest immunity and the grant of anonymity to certain witnesses. Despite the bereaved family being

[246] Original inquest file of Ian Garfield Gordon accessed on 30 July 2018 at Shrewsbury Coroner's Court.

legally represented, the coroner refused the pre-inquest disclosure of evidence to them on the grounds that it was a breach of trust or confidence to disclose such information, with the witness list only being provided to the bereaved before the inquest but at a late stage.

During the preparatory stages of this inquest, the coroner obtained advice from outside counsel as to the identity of the witnesses required and the disclosure of evidence, adopting this advice unilaterally and without consultation with other interested parties. The coroner also appointed counsel to the inquest for the final hearing. Evidence was heard in a strictly chronological order with witnesses being recalled where necessary, thereby extending the time needed for the final hearing. The inquest was held in a hotel and lasted for three weeks with some sixty witnesses giving oral and written evidence. Other evidence included CCTV footage, surveillance footage, evidence

from a forensic consultant specialising in the analysis of tape recordings at the time of the shooting and a visit by the jury to the scene of the shooting.

The coroner invited written representations from the interested parties as to the verdicts to be left to the jury to consider. The family of Mr. Gordon asserted that the police had put themselves 'in harm's way' and the coroner subsequently left the verdicts of lawful and unlawful killing together with the alternative of an open verdict to the jury to consider. After four hours of deliberation, the jury returned a majority verdict of lawful killing. After the conclusion of the inquest, the coroner wrote a Prevention of Future Deaths Report to the Home Office regarding the future conduct of firearms incidents.[247]

After the inquest had concluded, INQUEST expressed dissatisfaction with how the inquest had been conducted and complained that the coroner hearing this inquest had created an adversarial forum with the bereaved family in the dock.[248]

[247] The Coroners Rules 1984, r 43. This rule provided a Coroner with the power to write a 'Prevention of similar fatalities report' addressed to the person or authority who may have power to take such action as may be necessary to prevent a further fatality occurring in similar circumstances.
[248] INQUEST Bulletin on the inquest of Ian Garfield Gordon, August 1993.

5.2.3 Derek Wallbanks [249]

On 12th October 1991, Derek Wallbanks was fatally shot by armed officers in Northumbria after a 'tip off' to police in circumstances that were unclear, but at a time when Mr Wallbanks was in breach of his bail conditions in respect of other offences. Believing Mr Wallbanks to be armed and to have fired his weapon at police officers, Mr Wallbanks was shot by a firearms officer in what was considered return fire. Subsequently, Mr Wallbanks' gun proved to be a starting pistol incapable of being fired. The Police Complaints Authority requested the Cumbria Constabulary to conduct an investigation into the circumstances surrounding the shooting.

The retained inquest materials were sparse and contained few details about its management, preparation or final hearing. At the inquest held at the Newcastle Coroner's Court, the bereaved family and the police force were recognised as interested parties with no apparent separate recognition of interested party status provided for the armed officers. There were no oral preliminary hearings held by the coroner and pre-inquest disclosure of evidence was not provided to the family.[250] The final hearing was held during April and May 1992 and lasted for three weeks with evidence of fifty-one witnesses being heard by or read to the jury. The jury returned a verdict of lawful killing. The bereaved family had initially appeared to have accepted the necessity of the police actions but a family member subsequently blamed the police officers for Mr Wallbanks' unnecessary death although no Prevention of Future Deaths Report appears to have been considered to have been necessary by the coroner.

[249] Original inquest file accessed on 12 April 2019 at Newcastle upon Tyne Coroner's Court. This file was particularly sparse with few details regarding the interested parties and their legal representatives (if any). The parents of Mr Wallbanks were elderly and in poor health. Mr Wallbanks' stepfather, was initially accepting of the police actions but later came to blame them for unnecessarily shooting his stepson who had taken his name but whom he had not formally adopted.

[250] This particular coroner had a policy in line with the then 1980's legislation of not providing pre inquest disclosure of evidence to the family of the deceased on the grounds that that there was no requirement to do so and case law had held that documents produced by the police were confidential and not disclosable without the force's permission.

5.2.4 Barry Clutterham[251]

Barry Clutterham was fatally shot on 27th February 1992 by armed police officers from the Suffolk Constabulary after he had wounded an unarmed police officer using a sawn-off shotgun and had taken a passing driver hostage. Mr Clutterham's death was reported by the Suffolk Constabulary to the Police Complaints Authority who instructed Essex Police to conduct an investigation with the terms of reference being To carry out an investigation into the circumstances leading up to and surrounding the fatal shooting by police of Mr Clutterham on 27th February 1992'. This investigation was concluded with a report on 18th May 1992, with the CPS deciding on 27th May 1992 that no criminal charges would be brought against any police officer involved in the armed operation. The inquest was held at the Suffolk Coroner's Court, in which the family, the Suffolk Constabulary and the armed officers were recognised as interested parties. The family does not appear to have been legally represented at the inquest, unlike the other interested parties.

From the relatively sparse materials retained in the inquest file, it appears that the coroner did not hold any preliminary review hearings although preliminary issues of public interest immunity and the anonymity of police witnesses arose. The pre-inquest disclosure of evidence was not provided to the bereaved family. The final inquest hearing concluded on 31st July 1992 after lasting three days and was considered the oral and written evidence of approximately thirty witnesses. The coroner left verdicts of both lawful and unlawful killing to the jury who reached a verdict of 'lawful killing.' The coroner did not write A Prevention of Future Deaths Report after the inquest concluded.

5.2.5 David Howell [252]

On 20th November 1996, police were called to a disturbance at the home address of David Howell. Mr. Howell left the premises before he could be taken into custody and

[251] The original inquest file of Barry Clutterham was accessed on 7 December 2018 at Suffolk Coroner's Court.
[252] Original inquest file of David Howell accessed on 22 May 2017 at Birmingham Coroner's Court.

went to a local supermarket where he held the shop manager captive with a knife and was subsequently fatally shot by armed officers from the West Midlands Police. At the request of the PCA, an investigation was carried out by the Metropolitan Police Service. The inquest was opened on 28th November 1996 and held at the Birmingham Coroner's Court.

The ambit of the inquest was confined to the immediate circumstances leading to Mr. Howell's death, although the coroner obtained Mr Howell's medical records in preparation for the inquest as he had a history of mental illness that was considered to be relevant. Birmingham City Council was recognised as an interested party due to its responsibility for the provision of mental health services to the deceased in addition to the bereaved family and the Chief Constable of West Midlands Police. The file materials did not reveal whether individual armed officers were formally recognised as interested parties as the coroner appears to have treated them as witnesses although they were also legally represented as were the family and the Chief Constable.

There were no preliminary hearings held by the coroner in preparation for the final hearing. In considering the relevant evidence the coroner looked at the manual of Standard Operating Procedure for Armed Officers although neither this manual nor

any other evidence or the witness list was disclosed before the final hearing despite the bereaved family being legally represented.[253] The coroner refused a written request made by the bereaved family for oral evidence of two extra witnesses to be admitted on the grounds that it was evidence that was not relevant to the inquest. The final hearing was held seven months after the fatal shooting in which the jury heard from approximately twenty-seven witnesses over a period of six days. After ninety minutes of deliberation, the jury returned a verdict of 'lawful killing'. In concluding remarks, the coroner recommended the police officers for a commendation for their actions and did not consider that a Prevention of Future Deaths Report was necessary although the bereaved family described Mr. Howell's death as a 'needless killing'.

[253] In this inquest, the coroner returned this standard operating manual to the police force before the start of the final hearing and it was considered it to be covered by Public Interest Immunity and therefore non-disclosable to the bereaved family.

5.2.6 James Brady[254]

On 24th April 1995, police firearms officers from the Northumbria Police fatally shot James Brady during a planned operation while he was believed to have been carrying out a burglary of a social club together with a number of accomplices. The officers believed Mr Brady to be armed with a firearm although it later transpired he was carrying a small torch, which was mistaken for a gun. The inquest was opened on 19th May 1995 and adjourned pending the investigation of the shooting, which at the request of the PCA was carried out by Durham Constabulary and completed by September 1996. However, the inquest had to be delayed due to the criminal trials of Mr Brady's accomplices and was further delayed by the CPS reviewing its decision on whether there should be a prosecution brought against any armed officer. Having decided that no firearms officer would be prosecuted the inquest was able to go ahead.

The coroner recognised the bereaved family, the Chief Constable of Northumbria Police, a police superintendent and a firearms officer who had fired the fatal shot as interested parties. Three preliminary hearings were held during 1997, in April, June and July at which all interested parties including the bereaved family were legally represented, with individual officers provided with legal representation separate from that of the Chief Constable.

At a preliminary hearings, issues concerning the ambit of the inquest, the witnesses required, the disclosure of documentary evidence and the grant of anonymity to the armed officers were decided with the interested parties and their legal representatives. The family's legal representative sought a wider ambit to the inquest in reliance on the provisions of Article 2 under the ECHR. Initially, the coroner granted limited anonymity to the armed officer 'A' who had fired the fatal shot by agreeing that he could be known by a cypher but decided he was not to be screened when giving

[254] The original inquest file of James Brady accessed on 12 April 2019 at Newcastle upon Tyne Coroner's Court.
After the conclusion of the inquest of James Brady family members sought to challenge the outcome of the inquest on the grounds it had not been Article 2 compliant. The ECtHR dismissed the application having determined that the inquest had been sufficient to satisfy the procedural requirements of Article 2. *Bubbins v The United Kingdom* (2005) 41 EHRR 24.

evidence. This decision was successfully challenged by 'A' and the coroner's decision was subsequently quashed by the High Court. In a subsequent decision, the coroner directed the officer's identity would be protected by the use of both screens and a cypher. Initially, the coroner refused the disclosure of evidence as it was not his usual practice to do so. However, the Chief Constable made no objection to the pre-inquest disclosure of evidence and the coroner subsequently provided this to the bereaved family, although it remained subject to issues of confidentiality and public interest immunity being resolved.

The final hearing had been initially scheduled to be held on 15 September 1997 and had been expected to last three to five days, although this time estimate was later extended to eleven days. The inquest was finally held over two weeks in September 1998 with the earlier 1997 date having to be postponed, while the judicial review on the issue of anonymity was heard. The jury heard from some thirty-three witnesses with the inquest concluding on 25th September 1998 with an 'open' verdict. After the inquest the CPS reviewed its decision not to prosecute any firearms officer but left its decision unchanged. The inquest material retained did not record whether any Prevention of Future Deaths Report was written at the conclusion of the inquest.

5.2.7 Michael Fitzgerald [255]

Michael Fitzgerald was fatally shot by armed police officers from the Bedfordshire Police on 26th February 1998, following a call to the police by his girlfriend, who had seen but not recognised Mr Fitzgerald as he climbed through a window into his flat located in a busy residential area. At attendance by police, Mr Fitzgerald pointed a gun at police officers after which a siege situation developed during which he was seen to point a gun at several different times at the attending officers. Subsequently, the gun was found to be a replica and incapable of firing. The PCA requested Thames Valley Police to conduct an investigation, which found that Officer B had not committed a criminal offence in firing the fatal shot and the CPS did not instigate a criminal prosecution of any firearms officer.

[255] Original inquest file of Michael Fitzgerald accessed on 6 July 2018 at Bedfordshire Coroner's Court.

The inquest was held at Bedfordshire Coroner's Court. In preparation for the inquest the coroner held one oral preliminary hearing with the interested parties although many of the other issues, which included disclosure, public interest immunity and the anonymity of officers when giving evidence at the inquest were dealt with in written correspondence or decided by the coroner with minimal input from the interested parties. Although it was accepted that Article 2 of the Convention applied to this inquest, the coroner determined that the ambit of the inquest would not be extended to include an investigation into policy or procedural protocols and that there would be no disclosure of documents relating to policy, procedure or training manuals dealing with armed situations.

All interested parties were legally represented and included separate representation for several firearms officers as well as representation for the family. Despite opposition from the family's legal representatives and an unsuccessful judicial review challenge by several newspapers, the coroner granted anonymity to the firearms officers for the inquest. Most of the evidence was disclosed to the family on request although several statements from the principal officers were provided only one week before the final hearing.

The inquest was held over four days and heard from some twenty-five witnesses. Despite the family seeking a verdict of 'unlawful killing' the coroner allowed the jury to consider only a verdict of 'lawful killing'. At the conclusion of the inquest the jury asked the coroner to write a Prevention of Future Deaths Report to the Home Office concerning the availability of replica guns. Subsequently, the family of the deceased unsuccessfully challenged the inquest in the ECtHR on the grounds that it had not been independent; there had been an inadequacy of disclosure of evidence; an insufficiency of investigation and a failure to sufficiently engage the family of Mr Fitzgerald in the inquest process.[256]

[256] *Bubbins v The United Kingdom* (2005) 41 EHRR 24. The family's claims asserting a breach of Article 2 were dismissed although the court found there had been a breach of Article 13 and awarded 10,000 Euros for non-pecuniary loss on behalf of Mr. Fitzgerald's estate.

5.3 The case studies – analysis

The inquests, which form the subject matter of these case studies shared a number of similarities that were not subject or influenced by the discretionary powers of the coroner. These similarities included the conducting of the statutorily required investigation of the fatal shooting by the PCA; the necessary adjournment of the inquest until completion of that investigation; the continued adjournment of the inquest until the CPS decision on any prosecution; the mandatory adjournment of the inquest until the conclusion of any or any associated criminal proceedings and the character and identity of the interested parties comprising the bereaved family members, the police authority and its armed officers.

These case studies demonstrate that there were a number of issues that were common to these contentious inquests, which concerned the use of the coroner's discretionary powers. These included the holding of preliminary hearings and the provision of the pre-inquest disclosure of the documentary evidence. Table 4 provides a summary of how these inquests described in the case studies were managed by the coroner in each of the six local coroner's jurisdictions in which they were held.

Table 4: Summary of case studies

No.	Name of deceased Coroner's region	PIRH held	Evidence disclosed to PIPs	Date of death Date of hearing Length of hearing	Verdict
1.	Michael Alexander West London	No	No	26 April1990 May 1991[257] 1 week	Lawful killing

[257] The original Inquest file of Michael Alexander accessed on 6 December 2018. The final hearing of this inquest had to await the outcome of the criminal trial of Mr Alexander's accomplices, which concluded in December 1990.

2.	Ian Garfield Gordon Shropshire, Telford and Wrekin	No	No	12 August 1991 January 1992[258] 3 weeks	Lawful killing
3.	Derek Wallbanks Newcastle upon Tyne	No	No	12 October 1991 May 1992[259] 2 weeks	Lawful killing
4.	Barry Clutterham Suffolk	No	No	27 February 1992 July 1992[260] 3 days	Lawful killing
5.	David Howell Birmingham and Solihull	No	No	20 November 1996 June 1997[261] 6 days	Lawful killing
6.	James Brady Newcastle upon Tyne	Yes	Yes	24 April 1995 September1998[262] 3 weeks	Open
7.	Michael Fitzgerald Bedfordshire and Luton	Yes	Yes	26 February 1998 November 1998[263] 4 days	Lawful killing

Table 4 identifies the length of the delay between the date of death and the final hearing and the time required to conclude it. These data provide insight into how the coroner treated these contentious inquests and the extent and degree of participation of the interested parties in each of them and whether the bereaved had the opportunity to voice their views on the management of the inquest in preliminary hearings or

[258] The original inquest file of Ian Gordon accessed on 30 July 2018.
[259] The original inquest file of Derek Wallbanks accessed on 12 April 2018.
[260] The original inquest file of Barry Clutterham accessed on 7 December 2018.
[261] Original inquest file of David Howell accessed on 22 May 2017.
[262] Original Inquest file of James Brady accessed on 12 April 2019. The more than three year delay in concluding the inquest of James Brady was contributed to by the criminal trial and conviction of his accomplices. Other delays were attributable to the CPS and the Coroner's decision to hold preliminary hearings.
[263] The original inquest file of Michael Fitzgerald accessed on 6 July 2018.

challenge the official version of events given in the PCA report and other police statements at the final hearing.

Table 4 also illustrates the lack of opportunities the bereaved had to be able to meaningfully participate in the preparatory stages of the inquest and at the final hearing. The absence of preliminary hearings deprived the bereaved of an opportunity to make their concerns about the death of their family member known to the coroner and the other interested parties. As a consequence, the bereaved family was prevented from questioning whether the ambit of the inquest and the evidence relied upon by the coroner, would be sufficient to address these concerns and provide answers to them. Other issues that were central to the inquest included the grant of anonymity to police witnesses and decisions about the appropriate date, time and location of the final hearing which were dealt with by the coroner without any invitation extended to the bereaved to contribute their views on these matters, either in correspondence or in person at preliminary hearings.

The coroner's refusal to provide any or any early disclosure of documentary evidence to the interested parties had the effect of placing the bereaved in particular at a substantial disadvantage. The final hearing, was often the first occasion in which the details of their family member's death were provided by the firearms officers responsible for the discharge of their firearms. In contrast, the police body involved in the fatal shooting and its officers were not similarly disadvantaged, as they had either provided or had been provided with the evidence that was subsequently used at the inquest.

The absence of preliminary hearings also contributed to the relatively short period of delay that elapsed between the date of the deceased's death and its concluding hearing, with many inquest having been concluded within a matter of months from the date of death. This lack of delay may have curtailed the period of uncertainty and distress experienced by the bere aved it also called into question the efficacy of the inquest from which the bereaved had effectively been excluded. The bereaved's lack of opportunity to prepare questions and challenges to the evidence of the police witnesses at the final hearing, contributed to the coroner being able to hear and conclude the inquest within a matter of days. Final hearings that took weeks to conclude did not

automatically translate into a greater degree of participation by the bereaved and were susceptible to the idiosyncratic style of the coroner in the management of the evidence and the order of the witnesses.

The 1998 inquest files of James Brady and Michael Fitzgerald are two exceptions that demonstrate that despite the HRA not having come into force, the bereaved and their representatives had begun to place reliance on Article 2. The impact of this demonstrated by the differences in management of these inquests by the coroner and the willingness of the bereaved to challenge decisions made in preparation of the final hearing.[264] In both of these contentious inquests, the coroner accepted that Article 2 was engaged and in furtherance of its requirements, held preliminary hearings and provided the disclosure of evidence to the interested parties. These inquests also illustrated how in the absence of a national coronial service, the coroner was able to exercise a wide discretion as to a particular contentious inquest would be managed.

Despite recognising the engagement of Article 2 in the inquest of Michael Fitzgerald, only the coroner in the inquest of James Brady extended the ambit of the inquest to include an investigation of the wider circumstances that led to the fatal shooting. Although these inquests represented a divergence from the previous almost unilateral control the coroner exercised over these contentious inquest proceedings, they also demonstrate the coroner's individual approach to them during a period when the Human Rights Bill was passing through Parliament and at a time of the ongoing public inquiry into the death of Stephen Lawrence. This inquiry recommended in its report that there should be advanced disclosure of evidence and documents as of right to parties who have leave from a coroner to appear at an Inquest.[299] Consequently, these

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case studies signalled that the unilateral decision-making of the coroner was beginning to change and that the bereaved sought a greater role in these inquests and recognition by the coroner in these inquests.

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[264] At the time of these inquests the Human Rights Act had yet to come into force and therefore reliance had to be placed on the UK's position as a signatory to the ECHR rather than through the HRA. [299] Home Department, The Stephen Lawrence Inquiry Report, (Cm 4262–1 1999) para 42, 379 ('The McPherson Report').

5.4 The remaining inquests of 1990 to 2000

Access could not be obtained to the original inquest file materials for the remaining nine inquests that were held in seven coroner's regions and concluded in this period. However, published information about each of them was available from alternative sources.[300] Although this material did not include the same level of detail on the preparatory stages of the inquest as contained in the original file materials, it identified the date of the final hearing, the time taken to conclude it and the verdict reached by the jury. However, for a small number of inquests, not all of this information was included in local and national media or other published sources, see Table 5.

Table 5: The remaining contentious inquests of 1990 to 2000

No.	Name of deceased Coroner's region	Date of death Date of final hearing Length of hearing	Verdict
1.	Kenneth Baker Surrey	27 November 1990 April 1992[301] Unknown	Lawful killing
2.	Ian Bennett West Yorkshire Western	1 January 1992 July 1992[302] 6 weeks	Lawful killing
3.	Peter Swann South London	23 June 1992 September 1993[303] 1 week	Lawful killing
4.	David Luckhurst Hertfordshire	18 April 1993 1994[304] Unknown	Lawful killing

[300] Although permission was given to access the file of Diarmuid O'Neill it was not found in the archived files kept by the West London Coroner's Court.

[301] Stephen Smith, *Stop! Armed Police! Inside the MET's Firearms Unit* (Robert Hale Press 2013) 103, 105. The inquest into the death of Kenny Baker was delayed while his accomplices were tried and convicted at the Old Bailey in November 1991.

[302] YorkshireLive, 'Alistair Bell's death latest in Christmas tragedies,' (YorkshireLive, 29 Dec 2010) updated 28 Nov 2017 <www.examnerlive.co.uk.. . .>Alfred Moore> accessed 20 July 2020.

[303] Mike Waldren, *The Police Use of Firearms since 1945* (Sutton Publishing Ltd 2007) 175, 176.

[304] Stephen Smith, *Stop! Armed Police! Inside the MET's Firearms Unit* (Robert Hale 2013).

No.	Name of deceased Coroner's region	Date of death Date of final hearing Length of hearing	Verdict

5.	Ian Hay Plymouth, Torbay and South Devon	13 October 1993 November 1994[265] 2 weeks	Lawful killing
6.	David Stone Inner London North	15 October 1993 1994[266] Unknown	Lawful Killing
7.	John O'Brien Inner London North	27 July 1994 June 1995[267] 2 days	Lawful killing
8.	Robert Dixon West Yorkshire Western	27 December 1994 1995[268] Unknown	Lawful killing
9.	Diarmuid O'Neill London West	23 September 1999 January 2000[309] 3 weeks	Lawful killing

5.5 The remaining inquests of 1990 to 2000 – analysis

Despite the lack of a statutory time limit in which the coroner was required to conclude a contentious inquest, the adoption of a uniform time-frame was precluded by a number of factors. These included the local nature of the inquest service; the variations of approach by coroners; differences in resources among coroner regions; the degree of efficiency of the particular police body nominated by the PCA to investigate the shooting; the time taken by the CPS to decide not to prosecute a firearms officer and the completion of any criminal proceedings for alleged accomplices of the deceased. Therefore, as a general, but by no means inviolate rule, the shorter the period of delay in concluding the inquest and the less time spent on the final hearing, the greater the likelihood that the bereaved were effectively limited in their ability to play any

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[265] *Robert and Dinah-Anne Hay v the United Kingdom* App no 4894/9 (ECHR, 17 October 2000). The claimants (siblings of the deceased) sought further monetary damages after settlement of their earlier civil suit against the police force.
[266] Stephen Smith, *Stop! Armed Police! Inside the MET's Firearms Unit* (Robert Hale 2013) 126 127.
[267] Stephen Smith, *Stop! Armed Police! Inside the MET's Firearms Unit* (Robert Hale 2013) 127 129.
[268] Stephen Smith, *Stop! Armed Police! Inside the MET's Firearms Unit* (Robert Hale 201) 126.
[309] Although access to the original inquest file of Diarmuid O'Neill file was permitted, this file was not found at the off-site storage facility used by West London Coroner's Court.

meaningful part at any stage of the inquest process, thereby preserving its coroner led inquisitorial nature.

The summary of these nine inquests shown in Table 5 indicates that it was likely the bereaved family had been precluded from having any meaningful participation in the majority of these inquests. This is demonstrated by the absence of any substantial delay between the date of death and the final hearing and the time taken to conclude the inquest. Despite the highly individual circumstances of each death and the absence of greater detail as to the preparatory steps taken in each inquest, a comparison of both the period of delay in concluding the inquest and the length of the final hearing compared with the same information recorded in the case studies indicates a strong likelihood of a similar absence of preliminary hearings and pre-inquest disclosure of evidence.

As a practical matter, those inquests that lasted just a few days were unable to have allowed sufficient time for the bereaved or their legal representative to been able challenge effectively or at length the evidence of oral witnesses, even if in the unlikely event, it been disclosed to them beforehand. Even where the bereaved were legally represented, inquests that were held over a longer period did not automatically equate to a greater opportunity for the bereaved to meaningfully participate in the inquest, as the management of the final hearing was subject to the idiosyncratic approach of the coroner. This was demonstrated by the coroner in the inquest of Ian Gordon and the recalling of witnesses in order to strictly maintain the chronological order of the evidence which added to the time taken to conclude the final hearing.

The final contentious inquest held in this period concerning the death of Diarmuid O'Neill, signalled the inquisitorial nature of the inquest and the coroner's use of discretionary powers was coming under challenge by the bereaved with the imminent coming into force of the HRA This apparent attrition of the inquisitorial inquest was recognised by the coroner at the conclusion of this inquest who commented after the jury had reached its verdict:

> This is a democratic society. That society has required the police officers to take risks on our behalf. We ask them to do it. I have subjected them to three weeks' sustained attack without the protection afforded by the criminal court,

> with no pretence of natural justice and there is nothing that I can do about it. The need to change the law to prevent this is, to me, overwhelming.[269]

5.6 The PCA and CPS

With the exception of the inquest of James Brady the inquests held in this period did not exhibit any inordinate period of delay in their being concluded. Some delay to the inquest was unavoidable and attributable to the time taken for the independent investigation to be completed by the PCA and a decision reached by the CPS on whether or not to prosecute any police officer or officers for their role in the fatal shooting.[270] Although made up of members who were not and had never been serving members of any police force, the PCA did not escape from criticisms of cronyism and bias as they were perceived to be police officers investigating other police officers.

Once notified of a fatality arising from a shooting by armed police, the PCA was responsible for nominating a police force that was unconnected with the shooting, interviewing witnesses and the gathering of other relevant evidence. The investigation was concluded by the provision of a written report of its findings for submission to the PCA. In the majority of cases, the PCA investigation would be handed to a neighbouring or other police force not associated with the police authority to which the armed officers belonged. However, in a minority of occasions, the investigating body appointed by the PCA was the same police authority whose firearms officers had carried out the fatal shooting.[271]

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[269] The original materials relating to the Diarmuid O'Neill inquest were apparently 'misfiled' as although permission to access them was granted, the file was not found.
Amnesty International, 'United Kingdom: Questions remain after the inquest into the death of Diarmuid O'Neill' (AI Index: EUR 45/41/00).
Mr. O'Neil was suspected of involvement with the Irish Republican Army (IRA) and in plans to carry out terrorist activities in the UK. After a request for a public inquiry was refused by the Home Office, the coroner held a three-week inquest in which the family were legally represented and during which the relationship between the Coroner and the representative for the family became increasingly acrimonious.

[270] Police and Criminal Evidence Act 1984, pt IX. This provision created the Police Complaints Authority (PCA) and replaced the Police Complaints Body. On the notification of a fatal police shooting the PCA would nominate a local police force to carry out an investigation into the fatal shooting. Once the investigation was complete the findings would be communicated to the PCA who in turn would compile its final report.

[271] In the investigation into the death of Diarmuid O'Neill the Metropolitan Police Service was both the force whose officers had carried out the armed operation and which carried out the PCA investigation.

In the absence of available personnel and the lack of financial resources to carry out its own independent investigation, the coroner was largely reliant on the statements gathered during the PCA investigation. These statements formed the basis of the evidence that was used at the final hearing of the inquest and from which most witnesses were required were identified.[272] However, this reliance on the PCA's investigation contributed to a perception held by the bereaved, that the coroner's investigation was from its inception fundamentally flawed and biased in favour of the police force and its officers. Further, the treatment of police officers under investigation, as witnesses rather than as suspects reinforced the view held by the bereaved, that armed police officers were provided with privileges and more favourable treatment than enjoyed by ordinary members of the public and led to legal challenges to the post incident procedures that the armed officers were permitted to follow.[273]

Once the investigation by the nominated force was completed, a copy of the PCA report would be passed to the CPS to assist in its decision making on whether any criminal charges should be brought against any officer involved in the fatal shooting. However, the CPS' failure to involve the bereaved in its decision-making process, left family members with a lack of any, or any detailed explanation of how the decision not to prosecute any individual officer for the death of their family member had been reached. This apparent lack of transparency by the CPS added to the already held perception that from the outset, the police force and its officers received unfairly favourable treatment which continued up to and throughout the inquest. The absence of a jury verdict of 'unlawful killing' in all of these contentious inquests of this period, even on the occasion where the jury was allowed to consider this verdict together with

[272] Police Complaints Authority Annual Report 1991, para 2.9 (HC Papers, 1 May 1992). The normal process would be for the coroner to make a formal request for the statements gathered in the course of the investigation.

[273] One of these challenges concerned the practise of armed officers conferring with one another immediately after the fatal shooting and before having made their initial statements. Subsequently, the post incident procedures followed by officers have been subject to further scrutiny and amendment. <https://www.app.college.police.uk/app-content/armed-policing/post-deployment/#post-incidentprocedures> accessed 26 May 2020. The College of Policing defines a Post Incident Procedure (PIP) is a formally defined process, providing a means of securing and preserving evidence relating to a police incident and obtaining untainted personal accounts from officers based on their honestly held belief. Therefore, officers and staff should not confer before making their accounts (whether initial or subsequent detailed accounts). It is important that key police witnesses individually record what their honestly held belief of the situation was at the time force was used. There is, therefore, no need for an officer to confer with others about what was in their mind at the time force was used.

other alternatives, did little to reassure the bereaved the death of their family member had been fully and fairly investigated or that any failings identified on the part of the police or its armed officers would be remedied.

5.7 Legal funding

The absence of the provision of public legal funding for inquests during the 1990's which would have enabled the bereaved to actively participate in these contentious inquests, or at least, to the extent the coroner permitted was justified by the official view that these inquests were not adversarial but inquisitorial. During this period, the official view persisted that as there were no claimants or defendants and no 'case to put' to any witness and no apportionment of any civil or criminal fault, legal representation was unnecessary.[274] The official view remained that the coroner would conduct the questioning of witnesses and elicit the information required by the jury to answer the four questions including 'how' the deceased died. Consequently, during this period of inquests, the grant of legal funding was narrowly confined to those which raised issues of 'exceptional circumstances' and to which a means test also applied. Where bereaved families were represented in inquests held in this period, this would have been likely to have resulted from the free representation provided by lawyers whose professional interests aligned with those of the bereaved.[275]

5.8 Conclusions

The case studies that were based on the materials accessed in the original inquest files revealed these inquests were, with a single exception concluded within months of the death having been reported to the coroner. The lack of delay in concluding these contentious inquests was also extended to the others held in this period. The absence of any substantive delay in concluding the inquests described in the case studies can be attributed to, the exercise of the coroner's wide discretionary powers in excluding both the holding of preliminary hearings and the provision of the pre-inquest disclosure of evidence for the benefit of all interested parties.

[274] The Coroners Rules 1984, r 42.
[275] INQUEST maintains a roster of lawyers who are members of its Lawyers Group and who may offer their services on a non-paying basis to the bereaved.

This lack of delay in these coroner-led inquests had the practical effect of excluding the bereaved were prevented from being able to make any informed challenges to the management of the inquest and the evidence of the police authority and its witnesses as, unlike the police body and its armed officers, the bereaved were reliant on the inquest to provide a detailed account of the death of their family member. This lack of involvement on the part of the bereaved called into question the therapeutic benefit of the inquest in which they received neither public recognition of their loss of their family member in the form of an 'unlawful killing' verdict, or any form of punitive justice by a positive review by the CPS of its decision not to prosecute those responsible for the death.

By focusing upon the date of death, the date of the final hearing and the time taken to conclude it, comparisons can be made between the case studies as well as with the other nine inquests held in this period, but for which access to original file materials could not be obtained. These nine inquests like the case studies, also demonstrate that in the majority of them, there has been little delay between the death being reported to the coroner and the conclusion of the final hearing. Therefore, by analogy with the case studies, it is reasonable to draw the inference that in these nine inquests it was unlikely that any preliminary hearings were held by the coroner and that the disclosure of evidence was similarly not provided to the interested parties.

An exception to this efficiency of management shown by the coroner is demonstrated by the inquest of James Brady in which, the coroner accepted that Article 2 was engaged and extended the ambit to include matters of police planning and policy. Also, in contrast to the majority of the inquests concluded in this first period is the three week inquest of Diarmuid O'Neill. These inquests held at the end of the 1990's suggest that the contentious inquests began to acquire an ambit of increased complexity which led to longer hearings and allowed opportunities for challenge to the coroner's decisions and a growing adversarialism in the inquest forum.

In order to maintain consistency and allow comparisons between the three inquest periods of this research, the methodology used in this chapter is replicated in Chapter Six. This chapter considers in greater detail, the inquests that were concluded during the period 2001 to 2012, which saw the implementation of the HRA and the automatic engagement of the investigative obligation of its Article 2.

CHAPTER SIX: THE CONTENTIOUS INQUESTS 2001 to 2012

6.0 Introduction

The Human Rights Act 1998 received Royal Assent on 9 November 1998 and came into force on 2 October 2000. The implementation of the HRA saw the automatic engagement of Article 2 to inquests where a death had occurred at the hands of the state. The decisions of the ECtHR during this period established that Article 2 required a state not only to protect life but also required a proper system of investigation where a death had occurred at the hands of the state or its agents.[276] Article 2 also imposed additional investigative requirements on all public organisations and services that were prescribed a statutory role in the scrutiny of a fatal police shooting. Consequently, the investigations conducted by the PCA, its successor the IPCC and the decision-making process employed by the CPS on whether or not to bring a prosecution, were all subject to these additional investigatory requirements as well as the inquisitorial forum of the inquest.[277]

Where Article 2 applied to an inquest, the coroner was required to investigate the wider circumstances leading up to the death, specifically where questions arose as to whether there had been systemic failings by the state or its agents which had caused or contributed to the death. Consequently, the inquests of these police-shooting deaths that were concluded between 2001 and 20012, required the question of 'how' to be extended from being an investigation into the immediate events leading to the death to include 'and in what circumstances'.[278] For groups representing the interests of the bereaved, the essential features of an Article 2 compliant investigation into a contentious death, were categorised as independence, effectiveness, promptness and reasonable expedition, public scrutiny and accessibility by the family of the deceased

[276] *Jordan v United Kingdom* (2003) 37 EHRR 2. See also *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653.
[277] The Code for Crown Prosecutors, October 2018 para 2.10. This states that prosecutors must apply the principles of the European Convention on Human Rights, in accordance with the Human Rights Act 1998, at each stage of a case < www.cps.gov.uk>publication>code-crown-prosecutors> accessed 27 July 2020.
[278] *R (Middleton) v Coroner for the Western District of Somerset* [2004] UKHL 10.

to the investigative process with a failure to comply with these requirements was regarded as amounting to a violation of Article 2.[320]

Each of the thirty-one inquests that resulted from a fatal shooting by firearms officers in the period of 2001 to 2012 engaged the investigative requirements of Article 2. The nature and extent of the changes that Article 2 brought to these contentious inquests form the subject matter of this chapter. As in the previous chapter, access to the original inquest materials was requested and where made available, the files were reviewed by applying the same set of standardised questions as used for the earlier case studies. Similarly, for those inquests where access to original case materials was unavailable, other published sources were utilised which provided the date of death, the date of the final hearing and the time taken in which to conclude it. As in the previous chapter, these sources included media reports and press releases from family campaigns and interest groups as well as accounts published by former firearms officers and law reports where challenges to the inquest had subsequently been made.

6.1 The contentious inquests

As one inquest was converted to a public inquiry,[321] thirty inquests were concluded during this period with three inquests concerning deaths that had occurred in the earlier period of 1990 to 2000.[322] Of the concluded inquests, twenty-six resulted in a jury verdict of lawful killing, two inquest juries recorded an open verdict and two inquests

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320 INQUEST/INQUEST Lawyers Group/Police Actions Lawyers Group Briefing – March 2006 <www.palg.org.ukapp>downloads>Fatal+shootings+> accessed 28 July 2020.

321 Home Office, Government Response to Anthony Grainger public inquiry (May 2020) <www.gov.uk>Crime, justice and law> accessed 20 October 2020.

Mr Grainger's death arose from a Greater Manchester Police covert investigation called Operation Shire. He was shot dead in Culcheth by an armed firearms officer of Greater Manchester Police on 3 March 2012. .The inquest into Anthony Grainger's death was converted into a public inquiry under the Inquiries Act 2005 because it was not possible to share with a jury certain sensitive information the coroner deemed central to the scope of the inquest and to meet the enhanced range of procedural mechanisms available to a statutory inquiry were needed to enable compliance with the investigative obligation under article 2 (right to life).

The inquiry had the same scope as the inquest: "To ascertain when, where, how and in what circumstances Mr Anthony Grainger came by his death during a Greater Manchester Police operation, and then to make any such recommendations as may seem appropriate. The Anthony Grainger Inquiry Report was published on 11 July 2019.

<http://www.graingerinquiry.org.uk/wp-contet/uploads/2019/07Anthony-Grainger-InquiryReport.pdf> accessed 27 July 2020.

[322] These concerned the inquests of Harry Stanley, Kirk Davies and Patrick (Kieron) O'Dowd whose inquests were concluded in 2005 and 2002 respectively.

concluded with the controversial and unusual verdict of 'suicide by cop'.[279] Although the CPS Code required it to consider the duties and obligations owed under the HRA, none of these police-shooting deaths or their inquests resulted in a criminal prosecution of the firearms officers.[280] However, charges for breaches of health and safety law against the appropriate corporate police bodies resulted in convictions.[281]

The original files materials that form the basis of the case studies in this chapter were accessed by appointment at the coroner's court in the jurisdiction they had been heard. The exception required the viewing of the original inquest materials at the off-site secure storage facility in which the file was now held.[282] As with the other inquest material that had been previously accessed, these inquest files also varied considerably as to the material retained and ranged from being nearly complete to the sparse. In seeking answers to the same questions and information sought in the earlier case studies, this allowed comparison between the two periods of inquests to be made and analysed to determine if these later inquests differed from those that had been held in the previous decade and to assess the cause or causes for this.

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[279] This was a type of short form verdict that had not been previously recorded and was not welcomed by INQUEST describing it as "a perverse verdict and an extremely dangerous precedent, an attempt to distract attention from the lawfulness of the police use of firearms.

News Shopper, '"Suicide by cop" verdict condemned' (News Shopper. 15 May 2003) www.newsshopper.co.uknews>6247813.suicide-by..> accessed 25 May 2020.

[280] Police Complaints Authority, *Review of shootings by police in England and Wales from 1998 to 2001*, (HC313, 2003) Article 2 of the ECHR does not establish entirely new grounds to justify deprivation of life. It recognises the lawful use of legal force e.g., in reasonable self or third party defence, including where a police officer is honestly mistaken as to the threat posed by the person killed. When deciding whether a fatal shooting is 'absolutely necessary', the following will still have to be considered: the firer's purpose; the threat posed by the actions of the person shot; and the risk that the force used will cause loss of life.

[281] The Metropolitan Police Service was successfully prosecuted under the Health and Safety Act 1974 over 'operational errors' in planning and communication that led to the death of Jean Charles de Menezes. In the death of PC Ian Terry (not included in this research due to the death having occurred during a police training exercise rather than of civilian) charges for breaches of health and safety were brought against the Greater Manchester Police to which it pleaded 'guilty'.

[282] Although this storage facility had been reported to have stored two of the inquest files of this period of inquests, only one was located with the other presumed to have been misfiled or destroyed.

6.2 Case studies

As the HRA and the demands of Article 2 became embedded in the inquest forum, coroners were required to hold an inquest that not only investigated the wider circumstances of the death but also ensured the inclusion of all interested parties in both the preparatory stages of the inquest as well as at the final hearing. How and to

what extent this requirement was implemented is examined in the following seven case studies. As in the previous case studies a short description of the events that led to each death has been included, to provide a degree of context to the circumstances in which these inquests were held.

6.2.1 Andrew Kernan [283]

Andrew Kernan was fatally shot by police on the 12th July 2001 after his mother had called for emergency assistance after he had been seen brandishing a sword while suffering a schizophrenic episode. The shooting was referred to the PCA who requested the Greater Manchester Police to conduct an investigation. However, as the PCA had not concluded its report by 1st April 2004, the new independent body of the IPCC took over the investigation as it had from this date assumed the responsibility for investigating such deaths.

In the preparation of the inquest's final hearing, the coroner held several pre-inquest review hearings with the interested parties, which included Mr Kernan's family, the NHS Trust responsible for the provision of care to Mr Kernan for his mental health, the Chief Constable of the Merseyside police and the individual police officers who had been directly involved in the shooting. All interested parties were legally represented with the firearms officers having separate representation to their police authority employer. Representations were made to the coroner on behalf of the family as to the ambit of the inquest as they wished the inquest to consider issues of police officers' training and officers familiarity with dealing with persons with a mental health disability. However, this representation appears not to have been accepted by the coroner who decided instead upon the narrower ambit of the more immediate circumstances leading up to Mr Kernan's death.

[283] Original inquest file of Andrew Kernan accessed on 10 May 2017 at Liverpool Coroner's Court.

The final hearing was held over a two week period in 2004 during which the jury heard from over fifty-four witnesses, as well as being shown CCTV and surveillance footage of the scene. In summing up to the jury the coroner left the verdicts of lawful killing and open to the jury although the family had made submissions to the effect that an unlawful killing verdict should also be included as an alternative for the jury to consider. After several hours of deliberation, the jury recorded a verdict of lawful killing. A Prevention of Future Deaths Report appears not to have been written by the coroner after the inquest concluded.

Subsequently, the bereaved family unsuccessfully sought permission to challenge the outcome of the inquest. It was asserted the ambit of the final hearing had not been sufficiently wide, the short form verdict did not address issues of police officers' training on issues of mental health and did not sufficiently reflect the jury's findings on issues that were central to the inquest. The High Court dismissed this challenge saying that a short form verdict was sufficient to satisfy the requirements of Article 2.[284]

6.2.2 Derek Bennett [285]

Derek Bennett was shot by armed police officers on 16th July 2001 after they had responded to a report of a man being seen with a gun. Subsequently, the gun was found to be a replica that was incapable of firing. Just over a week before his death, Mr Bennett had been the subject of a mental health assessment with a recommendation made that he should be detained in a mental health unit being assessed as a danger to himself and to others. This recommendation was not implemented and Mr Bennett remained in the community where he took a hostage and put a gun to the hostage's head. After being referred to the PCA, a request was made to Northumbria Police to conduct an investigation into the circumstances of Mr Bennett's death.

[284] The inquest file of Andrew Kernan records that permission to seek a judicial review of the inquest verdict was refused.
[285] Original inquest file of Derek Bennett accessed on 30 November 2018 at Inner South London Coroner's Court.

At the inquest, the family's legal representative raised issues of whether there was a 'shoot to kill' policy by the police force concerned and submitted at one of the many pre-inquest review hearings that were held, that this issue should be included in the ambit of the inquest. The bereaved family also wished to have included in the ambit of the inquest, an investigation into Mr Bennett's mental state and issues of racial sensitivity training due to the perceived racist element in the shooting and the negative police attitudes displayed towards sections of the Afro-Caribbean community. The

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family's legal representatives asserted that the inclusion of these issues would enable them to question officers in relation to their attitude on race and the ethnicity of Mr Bennett and whether this attitude may have influenced their handling of this incident and if they had received any training on these issues.

Other issues discussed with the coroner at the preliminary hearings included the disclosure of evidence, the use of expert witness reports and the redaction of sensitive documentary information. The coroner's decision to refuse the grant of anonymity to the firearms officers when giving their evidence at the inquest caused the preparations for the final hearing to be interrupted by successful judicial review proceedings brought by firearms officers.

The final hearing was held at Inner London Crown Court and evidence was heard from approximately ninety witnesses over a period of six weeks and included matters concerning the discharge of the NHS Trust's duties to Mr Bennett regarding his mental health. In summing up to the jury, the coroner considered it inappropriate on the evidence heard at the inquest to leave with them a verdict of unlawful killing despite the legal submissions from the family's legal representative that the jury should be allowed to consider such a verdict. After six hours of deliberation, the jury returned a verdict of lawful killing. Subsequently, the family of Mr Bennett brought unsuccessful judicial review proceedings challenging the coroner's decision not to

allow the jury to consider a verdict of 'unlawful killing'[286][287] and called the jury verdict 'An outrageous decision and a travesty of justice.'[331]

6.2.3 Keith Larkins [288]

Keith Larkins, who had a history of mental health problems, was fatally shot by police firearms officers on 6th June 2003 after being involved in a car chase around the perimeter of Heathrow Airport and having threatened unarmed officers with a blankfiring copy of a police-issue handgun.

At the inquest the coroner recognised seven interested parties, which included the bereaved family, the Chief Commissioner of the Metropolitan Police Service, the airport police, the individual armed officers, the Mental Health Trust responsible for providing care for Mr Larkins and the IPCC who had taken over the investigation. In preparation for the final hearing, at which all interested parties were legally represented, the coroner held two pre-inquest review hearings. These determined the ambit of the inquest, the witnesses to be called, the use of expert witnesses regarding psychiatric and firearms issues, the disclosure of evidence and public interest immunity issues including footage recorded by a helicopter which the bereaved family required to form part of the evidence and the issue of the grant of anonymity to the firearms officers.

During the ten day final hearing, the ambit of which included an investigation of Mr Larkins' mental health diagnosis and care, the jury heard from some thirty-five witnesses who included independent expert witnesses in the fields of psychiatry and firearms. In summing up by the coroner, the jury was left with a range of verdicts from which it could determine the issue of how Mr Larkins died. The jury reached a verdict of 'lawful killing' and included in its findings, criticisms of the mental health care provided to Mr Larkins.

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[286] *The Queen on the application of Bennett v HM Coroner for Inner South London v Officers A and B, Commissioner of Police for the Metropolis* [2007] EWCA Civ 617.

[287] WardEver, 'Lawful killing verdict returned by inquest jury' (4WardEver, 10 January 2005) <4waardever.org>cases>adult-cases-uk>shootings> accessed 24 May 2020.

[288] Original inquest file of Keith Larkins accessed 25 June 2018 at a secure off-site storage location used by West London Coroner's Court.

6.2.4 Philip Marsden[289]

On 19th December 2005, the first fatal shooting by armed police in Staffordshire, resulted in the death of Philip Marsden, who was shot at his home address after reports of a domestic disturbance. Mr Marsden was reported to have been seen to brandish a sword and a rifle both of which were later discovered to be imitation weapons.

After the opening of the inquest, the interested parties included the family of Mr Marsden, the Chief Constable of the Staffordshire Police and the four firearms officers. All interested parties were legally represented with separate representation provided for the firearms officers and independent from that of their police authority employer. Several pre-inquest hearings were held at which it was submitted on behalf of the family that the ambit of the inquest should include a consideration of whether proper procedures were followed in the police control room and whether the firearms officers had been briefed correctly particularly in respect of the imitation firearm.

The coroner determined that the police officers would be granted anonymity when giving their evidence at the final hearing, that evidence from a ballistics' expert would be heard at the final hearing and pre-inquest disclosure of evidence would be provided to all interested parties. Sixty-four witnesses were listed to give evidence to the inquest and the coroner decided that CCTV surveillance footage would be shown to the jury.

At the end of eight days of evidence, it was agreed among all legal representatives that a verdict of unlawful killing could not appropriately be left to the jury on the evidence heard during the final hearing. However, the family indicated that the jury should be asked to comment upon whether there were any failings by the police officers who had initially attended the scene to arrest Mr Marsden; whether there were any failings in the Control Room to pass on the relevant information to the armed officers; whether there was a failure to use ballistic protection or a failure to enter into any constructive dialogue with Mr Marsden. The coroner left the short form verdicts of 'lawful killing' and 'open' to the jury who after four hours of deliberations returned a verdict of 'lawful

[289] Original inquest file of Philip Marsden accessed 13 July 2018 at Stoke-on-Trent Coroner's Court.

killing'. Subsequently, the coroner addressed issues of control room staffing and negotiation training in the form of a Prevention of Future Deaths Report.

6.2.5 Andrew Markland and Mark Nunes[290]

Andrew Markland and Mark Nunes were fatally shot on 13th September 2007 by firearms officers during a planned operation involving both the Hampshire Constabulary and the Metropolitan Police Service during an armed robbery on a security van carrying cash, after a 'tip off' had been passed to the police. The criminal trials of the accomplices of the deceased took precedence and caused delay to subsequent inquest proceedings.

Once the criminal proceedings were concluded, preparation for the final hearing of the two consolidated inquests resumed. The coroner determined that the ambit of the inquest was to include the training of armed officers nationally and within the MPS in respect of the armed operation that had led to the deaths of Mr Markland and Mr Nunes. The coroner also decided that the ambit of the inquest would include scrutiny of all aspects of planning, command and control of this incident regarding the involvement of both the Hampshire Constabulary and the Metropolitan Police Service. The holding of several pre inquest review hearings were held and used to decide upon issues of disclosure of evidence, public interest immunity issues and anonymity of witnesses. The family was provided with full disclosure of the majority of the documents although only limited disclosure was provided of aerial footage shot from the police surveillance platform.

Unsuccessful judicial review proceedings interrupted the final hearing of these inquests. The family of Mr Nunes had sought the provision of the previously but mistakenly disclosed and recalled, unredacted interview of one of the police officers and a complete recording of the partially disclosed surveillance footage, on the grounds that the inquest would not otherwise be Article 2 compliant. A request to the

[290] Original Inquest files of Andrew Markland and Mark Nunes accessed on 31 March 2017 at Central Hampshire Coroner's Court.

coroner by a family member for the transcript of the criminal proceedings in respect of the deceased's accomplices was refused on the grounds it was too expensive and in any event, it was not relevant for the purposes of the inquest.

The jury heard from some fifty witnesses, including evidence from independent experts instructed by the coroner regarding the training and tactics utilised by the firearms officers. The inquest lasted almost six weeks, which period included the interruption caused by the judicial review proceedings and a site visit by the jury. In submissions made to the coroner by the interested parties as to the verdicts that could be left to the jury based on the evidence it had heard, the bereaved families invited the coroner to leave 'unlawful killing' or a narrative verdict to the jury. The coroner, however left only the verdicts of 'lawful killing' and 'open' and after four hours of deliberation, the jury returned with verdicts of 'lawful killing' in respect of the deaths of Mr Markland and Mr Nunes. The coroner did not appear to consider it necessary to write a Prevention of Deaths Report after the inquests had concluded, although details on this were unclear from the inquest materials retained.

6.2.6 Terry Nicholas [291]

On 15th July 2007, Terry Nicholas was shot by police firearms officers in West London during a planned intercept operation after information had been received by police that alleged Mr Nicholas was going to collect a firearm. Mr Nicholas was killed by firearms officers in return fire after having shot at them with a gun held in a sock that subsequently jammed.

At the first preliminary hearing held by the coroner, the Metropolitan Police Service raised a legal challenge to the coroner's jurisdictional powers to hear this inquest at all. The issue centred on the MPS' inability to disclose to the coroner the evidence obtained under the provisions of the Regulation of Investigatory Powers Act 2000,

[291] Original inquest file of Terry Nicholas accessed on 25 June 2018 at West London Coroner's Court.
[336] The coroner's refusal to hear the Azelle Rodney inquest on the grounds that it could not be Article 2 compliant if he was not to be provided with 'intercept' evidence, meant that after challenges brought by the family in the domestic and European courts, the government decided upon an inquiry for which a former High Court Judge was appointed, and to whom disclosure of evidence obtained under the Regulation of Investigatory Powers Act 2000 could be made.
Home Office, The Report of The Azelle Rodney Inquiry (HC 552, 2013).

which was the identical issue that had previously been raised at the inquest into the earlier death of Azelle Rodney in North London.[336]

In the inquest of Azelle Rodney the coroner determined that the evidence collected under the provisions of RIPA was central to the inquest and without it an Article 2 compliant inquest could not be held. In contrast, the coroner in the inquest of Terry Nicholas decided that it was possible to hold an Article 2 compliant inquest as it was not reliant upon the intercept evidence obtained under RIPA. As none of the interested parties sought to challenge this decision by way of a judicial review, preparations for the final hearing continued. After several further preliminary hearings during which the anonymity requested by the firearms officers was granted and the coroner provided disclosure of evidence to the interested parties, a final hearing that lasted for four weeks was held at Fulham Town Hall. At this hearing, significant security measures were put in place due to the alleged threat of potential retaliation for Mr Nicholas' death. These included the use of airport style arches, armed officers and sniffer dogs in the court before the start of the hearing each morning.

The ambit of the inquest included the earlier shooting of Mr Nicholas by unknown persons that had occurred outside his home two weeks before his death, as well as the planning and implementation of the firearms officers' intercept operation that led to his death. The inquest also included evidence commissioned by the coroner from an independent firearms expert in a letter of instruction in which the terms had been agreed by the coroner and the interested parties. At the conclusion of the evidence and in submissions to the coroner, the interested parties, including the representative for the bereaved family agreed that the jury should be directed to return the short-form verdict of 'lawful killing'. In addition, the jury was asked to provide their answers to a number of questions from which operational failings, if any, could be identified. The coroner determined that a Prevention of Future Deaths Report was not required.

6.2.7 Mervyn Tussler [292]

Mervyn Tussler was fatally shot by armed police on 8th May 2009 whilst in bed at his home address. Mr Tussler had been seen earlier that day standing in his doorway with a gun and threatening to shoot himself after becoming distressed by his wife having to be placed into care due to her poor state of health. On finding Mr Tussler in bed, officers went to render aid to him but he was seen to roll over with a gun in his hand which he fired at the officers who discharged their firearms.

The interested parties comprised the Chief Constable for the Sussex Police and the family of Mr Tussler with no apparent separate recognition of interested party status or legal representation for the firearms officers. The ambit of the inquest included an investigation into the planning of the operation, the use of negotiators and questions of whether family members should have been allowed to talk to Mr Tussler. It was not made clear in the few documents retained in the file, whether the coroner held any preliminary hearings. However, it was likely that at least one was held, as the disclosure of evidence had been provided at an early stage, although the bereaved family sought additional disclosure at the start of the inquest that concerned standard

operating procedure manuals, a request that was opposed by the Association of Chief Police Officers (ACPO) and refused by the coroner.[338]

The jury heard the oral and documentary evidence of some seventy witnesses over a period of three weeks, which included five forensic scientists and two independent police experts. The jury was also shown CCTV footage from a local shop and photographs of the local area. In submissions to the coroner, the bereaved family requested that questions that were wide in scope should be left to the jury to answer. In addition to the return of the short form verdict of lawful killing, the jury answered twenty-three questions that concerned the planning of and the implementation of the armed operation that had led to Mr Tussler's death. A Prevention of Future Deaths

[292] Original inquest file of Mervyn Tussler accessed on 25th April 2017 at Sussex Coroner's Court.

Report appears not to have been subsequently written by the coroner, although the inquest materials appeared far from complete on this issue.

Table 6: Summary of case studies 2001 to 2012

No.	Name of deceased Coroner's region	PIRH held	Evidence disclosed to PIPs	Date of death Date of hearing Length of hearing	Verdict
1.	Andrew Kernan Liverpool and the Wirral	Yes	Yes	13 July 2001 November 2004[339] 2 weeks	Lawful killing
2.	Derek Bennett Inner South London	Yes	Yes	16 July 2001 November 2004[340] 2 weeks	Lawful killing

[338] Original inquest file of Mervyn Tussler accessed on 25 April 2017. Legal questions arose as to confidential nature of some of the evidence, including audio evidence, for which a redacted transcript had been provided. A request for a full and unredacted transcript of the audio evidence was resolved by allowing the family limited access to the full audio recordings that they could check against the redacted version.

[339] Original inquest file of Andrew Kernan accessed on 10 May 2017.

[340] Original Inquest file of Derek Bennett. Accessed on 30 November 2018.

R (Bennett) v HM Coroner for Inner South London [2007] EWCA Civ 617. After the inquest, the bereaved family brought unsuccessful judicial review proceedings, which challenged the coroner's decision not to allow the jury to consider a verdict of 'unlawful killing'. The High Court considered that there was not a sufficiently great difference between the English definition of 'self-defence' and the 'absolute necessity' test provided by Article 2. The court held that the application of the test of selfdefence imposes in principle, a higher standard of care on firearms-trained police officers than, for example, on untrained civilians and to reach a 'lawful killing' verdict, the reasonableness test had to be met on the balance of probability, throughout the entirety of the incident concerned and regarding all the shots fired

No.	Name of deceased Coroner's region	PIRH held	Evidence disclosed to PIPs	Date of death Date of hearing Length of hearing	Verdict
3.	Keith Larkins West London	Yes	Yes	6 June 2003 June 2005[293] 2 weeks	Lawful killing
4.	Philip Marsden Staffordshire South	Yes	Yes	19 December 2005 September 2008[294] 2 weeks	Lawful killing

[293] Original inquest file of Keith Larkins accessed on 25 June 2018.

[294] Original inquest file of Phillip Marsden accessed on 13 July 2018.

5. & 6.	Andrew Markland Mark Nunes Wilshire and Swindon	Yes	Yes	13 September 2007 October 2011[295] 6 weeks (inquests heard together)	Lawful killing Lawful killing
7.	Terry Nicholas West London	Yes	Yes	15 May 2007 September 2009[296] 4 weeks	Lawful killing
8.	Mervyn Tussler West Sussex	Likely [297]	Yes	8 May 2009 October 2010[298] 3 weeks	Lawful killing

6.3 The case studies - analysis

As Article 2 applied to all public bodies charged with the investigation of each fatal shooting, delays between the date of death and the final hearing grew increasingly longer and commonly extended into years during this period of contentious inquests. These delays were attributable to a combination of factors and included the time taken in completing the PCA and the IPCC investigation and report, the criminal prosecutions of accomplices and delays by the CPS in reviewing the evidence and providing notification of its decision on whether a prosecution of any would be

forthcoming, all of which processes were required to be Article 2 compliant.[299] Once these matters had been concluded the coroner was permitted to proceed with the inquest, the concluding of which, was further delayed by the necessity of holding, often multiple preliminary hearings to meet Article 2 requirements as well as identifying suitable available accommodation for the final hearing for reasons of space and

[295] Original inquest files of Andrew Markland and Mark Nunes accessed on 31 March 2017.

[296] Original inquest file of Terry Nicholas accessed on 25 June 2018.

[297] The original materials that were retained in respect of this inquest were incomplete and indicative of the local interpretation of the requirement to retain documents relating to the inquest. As the coroner provided the interested parties with pre inquest disclosure of evidence, it is also likely that in order to hold an Article 2 compliant inquest other preparatory issue would have been subject to oral preliminary hearings.

[298] Original inquest file of Mervyn Tussler accessed on 25 April 2017.

[299] The IPCC had to power to set out in its report what has been found and the conclusions in which it is outlined whether a police officer may have committed a criminal offence and will then pass on the report to the CPS. The CPS is then responsible for deciding whether the person should be prosecuted. IPCC 'A guide to IPCC independent investigations' www.luton.gov.ukLists>Lutondocumets>PDF< accessed 29 July 2020.

security.[300] The judicial review challenges that were brought by interested parties to the coroner's decisions on anonymity and other preliminary issues were another source of delay the to the inquest being concluded.

The case studies demonstrate that two essential difference to the inquests of this period with those of the earlier decade, were the coroner's holding of preliminary hearings and the early disclosure of evidence to interested parties. Unlike the contentious inquests that were held in the 1990's the coroner during this second period of inquests, sought to meet the investigatory requirements of Article 2 by holding oral preliminary hearings with the interested parties and their representatives in attendance. At these hearings, the interested parties were provided with the opportunity to make known their views on the issues that were central to the inquest and which affected its efficacy and transparency.

The wider ambit of these contentious inquests saw requests made by the bereaved for the training records of police officers,[349] the standard operating procedure for armed officers,[301] the planning of the operation and its implementation,[302] the policy on the use of family members as negotiators,[352] the use of alternative non-fatal means of detention, particularly where the deceased had a history of a mental health disability

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and details of any training provided to armed police officers on how to deal with people suffering from mental health problems[303] and training of police officers on issues of race.[354] As these preliminary hearings provided the interested parties with the opportunity to raise their concerns, make challenges to the views of the other participants and seek to persuade the coroner of the appropriateness of their own, the inquest began to acquire a number of the attributes of an adversarial forum, all of which

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[300] Original Inquest file of Terry Nicholas accessed on 25 June 2018. The inquest of Terry Nicholas was relocated to Fulham Town Hall for reasons of space and availability, although required extensive security to be installed to protect the safety and anonymity of the armed officers as well as the personal safety of those attending. [349] Michael Fitzgerald inquest file.

[301] Inquest of Derek Bennet. The bereaved family wanted the inquest to investigate whether there was a 'shoot to kill' policy in place at the time of Mr Bennett's shooting.

[302] The inquests of Ian Gordon and Terry Nicholas are just two examples of where the planning and conduct of the armed operation were both investigated in the course of the final hearings. [352] Derek Wallbanks inquest file.

[303] Andrew Kernan inquest file. [354]
Derek Bennett inquest file.

contributed to the shaping of the inquest and tone of the final hearing. Unlike the majority of the previous case studies of the earlier period of 1990 to 2000, where the delay in holding the final hearing could be measured in months, the delays occurring in these case studies were now mostly measured in years, with the longest delay to concluding the inquest extending to four years.

In addition to these preliminary hearings, the early disclosure of evidence that was provided in these case studies reinforced the involvement of the bereaved in the inquest of their family member. Previously much of this evidence that was used at the inquest in the form of statements form police officers, had been regarded as the confidential property of the police authority that had provided it. However, Article 2 required the disclosure of evidence central to the purpose of the inquest as necessary for the purpose of ensuring the involvement of the bereaved. The disclosure of documentary evidence at an early stage provided an opportunity to the bereaved family to question and challenge police witnesses. This had the effect of extending the length of the final hearing and replacing the previously coroner led questioning of witnesses with more extensive questioning by representatives of the interested parties. Consequently, the final hearings often lasted weeks as the ambit of these inquests grew wider and the issues more complex, in contrast to the significantly shorter hearings of many of the case studies of the previous period.

These case studies also illustrate that despite the difficulty in securing public funding, the bereaved families were legally represented at these inquests. Whether this was through the exceptional public funding provisions for inquests, by way of private funding or the provision of free representation by lawyers sympathetic to their interests was not information provided in the inquest files.

6.4 Legal funding

Despite the added complexities introduced by Article 2 and its emphasis on the meaningful participation of the bereaved in all stages of the inquest, these did not translate into a positive impact on the provision of public legal funding, as it remained subject to the means and merits test and the exceptional funding criteria.[304] Many

[304] Legal Services Commission, *The Funding Code:* Decision Making Guidance (Part C). With effect from 1 November 2001 the Lord Chancellor issued an Authorisation to bring representation at a limited

bereaved families objected to having to pay for legal representation in a legal process into which they had unexpectedly become a party, but without which, they felt disadvantaged as the police force and its officers were invariably legally represented, whether separately or jointly. As a consequence of the onerous means and merits test imposed under the exceptional funding criteria, many bereaved families felt deterred from participating in the inquest and these legal funding rules actively discouraged them from doing so.[356]

6.5 The remaining inquests of 2001 to 2012

This group comprises the remaining twenty-two inquests that were held and concluded in twenty coroner's jurisdictions during this period. Although requested, access to the original materials of each inquest was not permitted on the grounds of confidentiality or ongoing litigation or due to the lack of a response to the multiple requests made to each senior coroner.[357] Therefore, reliance had to be placed on other published material, which although did not record the same level of detail that was found in the original file materials, nevertheless provided sufficient information from which the length of the delays in concluding these inquests could be measured. Frequently, this published material had recorded the length of the final hearing as well providing the inquest verdict. From this information, comparisons could be made between Article 2

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compliant inquests and those held in 1990's to which Article 2 had not routinely applied.

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category of inquests within the scope of public legal funding. If requested to do so by the Legal Services Commission, the Lord Chancellor could also authorise the commission to fund representation in individual cases. The Funding Code set out the following alternative grounds of granting this 'exceptional funding' on an individual basis if (i) There was a significant wider public interest in the applicant being legally represented at the inquest; or (ii) Funded representation for the family of the deceased was likely to be necessary to enable the Coroner to carry out an effective investigation into the death as required by Article 2 of the European Convention on Human Rights (the right to life). [356] INQUEST, 'INQUEST response to the Ministry of Justice Review of legal aid for inquests -call for evidence' (INQUEST August 2018). [357] See Appendix 3.

Table 7: Summary of remaining contentious inquests 2001 to 2012

No.	Name of deceased Coroner's region	Date of death Date of final hearing Length of hearing	Verdict
1.	Patrick (Kieron) O'Donnell Inner North London	30 October 2000 April 2002[358] 5 days	Lawful killing
2.	Kirk Davies West Yorkshire (Eastern)	24 September 2000 April 2002[359] 8 days	Lawful killing
3.	Steven Dickson Derby & Derbyshire	1 November 2001 November 2002[305] 4 days	Lawful killing
4.	Michael Malsbury North London	14 November 2001 May 2003[306] Unknown	Suicide (by cop)[307]
5.	Jason Gifford Buckinghamshire	24 June 2002 2004[308] 3 days	Suicide (by cop)
6.	Harry Stanley Inner North London	22 September 1999 October 2002[309] 1 week	Open (1st inquest restored after

358 BBC News, 'Siege man was lawfully killed' (BBC news online, 12 April 2002) <www.bbc.co.u>kuk_news>england> accessed 10 October 2020.
359 BBC News,, 'Police justified in killing former soldier'(BBC news online, 2 May 2002) <www.bbc.co.uk_news>england> accessed 25 May 2020.

305 BBC News England, ' Man pointed shotgun at police' (BBC news online, 6 November 2002) and 'Lawful killing after police shoot man' (BBC news online, 8 November 2002) www.bbc.co.uk>uk_news>england> accessed 26 May 2020.
306 Rebecca Allison, 'UK's first "suicide by cop" ruling, (The Guardian, 10 May 2003) <www.theguardian.com>may>UKcrime.ukguns> accessed 30 July 2020.
307 The controversial verdict of 'suicide by cop' was criticised by Deborah Coles of INQUEST who said 'This is a perverse verdict and an extremely dangerous precedent, an attempt to distract attention from the lawfulness of the police use of firearms. We will be exploring the legal validity of this verdict. It is vital that where the police resort to the use of firearms there is proper public scrutiny of their actions and whether or not they were lawful. This verdict has put the seal of official approval on police using firearms and mounting a suicide defence.' News Shopper, 15th May 2003 <www.newsshopper.co.uknews>6247813.suicide-by-...> accessed 23 October 2020.
308 Victoria Rosenberg, 'Police give gunman his suicide wish' (The Times. 8 January 2004) www.thetimes.co.ukarticle>police-gave-gunman-his-s...> accessed 20 October 2020.
309 The first inquest lasted one week at the end of which the jury recorded an 'open' verdict having been left with the option of deciding between 'lawful killing' and 'open' only.
Keith Lee, 'Open verdict on man shot by police' (World Socialist Website, 1 July 2002)<www.wsws.org>articles>2002/07>stan-j01> accessed 28 May 2020. This 'open' verdict was quashed by the High Court on an application for judicial review by the bereaved family.

No.	Name of deceased Coroner’s region	Date of death Date of final hearing Length of hearing	Verdict
		October 2004[365] 2 weeks	2nd inquest verdict quashed) Unlawful killing (2nd inquest quashed)
7.	Colin O’Connor Bedfordshire and Luton	23 January 2003 March 2005[310] 2 days	Lawful killing
8.	Fosta Thompson Avon	15 August 2002 November 2005[311] 3 weeks	Lawful killing
9.	Nicholas Palmer South London	12 May 2004 2005[312] Unknown	Lawful killing
10.	Philip Prout Plymouth, Torbay and South Devon	4 May 2004 October 2005[313] 6 weeks	Lawful killing
11.	Craig King Manchester South	10 September 2005 July 2006[314] 5 days	Lawful killing
12.	Mark Scott South Northumberland	16 July 2005 December 2007[315] 4 days	Lawful killing

[365] The second inquest lasted for two weeks and resulted in a verdict of ‘unlawful killing’.

[310] BBC News ‘Armed man’s killing was lawful,’ (BBC online news, 8 March 2005) <news.bbc.co.uk>_news>beds>bucks>herts> accessed 26 May 2020. See also <www.pressgazette.co.uk_- editor-beats-id-> accessed 26 May 2020.

[311] BBC News ‘dealer shooting lawful killing’ (BBC news, 25 November 2005) and ‘Man shot by police inquest told’ (BBC news. 7 November 2005) <news.bbc.co.uk _news>england>bristol>somerset> accessed 28 May 2020.

[312] The Telegraph, ‘De Menezes inquest: Jury reaches open verdict’ (The Telegraph*,* 12 December 2008) <www.telegraph.co.uknews>uknews.law-and order> accessed 29 May 2020.
Stephen Smith, *‘Stop! Armed Police!* (Robert Hale, 2013) 194,195. At the end of this inquest the coroner commended the armed officer who has fired the fatal shot.

[313] BBC News ‘Swordman’s shooting was lawful’ (BBC news, 11 November 2005) <news.bbc.co.uk >uk_news>england>cornwall> accessed 27 May 2020.

[314] BBC News ‘Gunman lawfully killed by police’ (BBC news, 27 July 2005) <accessed on 28 May 2020.

[315] The Journal, ‘Stocksfield shooting inquest verdict’ (The Journal, 13 December 2007) <www.thejournal.co.uk>News>North East News> accessed 27 May 2020.

Press Association, ‘Killing of man with table leg “unlawful” (The Guardian, 29 October 2004) <www.theguardian.com>oct>ukcrime1> accessed 28 May 2020.
This verdict was also later quashed by the High Court on a judicial review brought by the armed police officers. The High Court restored the original verdict of ‘open’ to avoid the need for a third inquest.

No.	Name of deceased Coroner’s region	Date of death Date of final hearing Length of hearing	Verdict
13.	Simon Murden East Riding of Yorkshire and Hull	22 March 2005 February 2008[316] 6 weeks	Lawful killing
14.	Jean Charles de Menezes Inner South London	22 July 2005 September 2008[317] 3 months	Open
15.	David Sycamore Surrey	30 November2008 August 2009[318] 5 days	Lawful killing
16.	Robert Haines Central and South East Kent	31 October 2006 January 2010[375] 2 weeks	Lawful killing
17.	Dayniel Tucker North West Kent	29 December 2007 February 2010[319] 1 week	Lawful killing
18.	Ann Sanderson North West Kent	11 June 2007 April 2010[377] 2 1/2 weeks	Lawful killing
19.	Andrew Hammond East London	29 October 2008 June 2010[320] Unknown	Lawful killing
20.	Mark Saunders West London	6 May 2008 September 2010[321] 2 1/2 weeks	Lawful killing

[316] Mailonline ‘Police “justified” in shooting charity worker inquest reveals’ (Mailonline, 2 April 2008) <www.dailymail.co.uknews>article-554388>Police-> accessed 26 May 2020.

[317] Richard Edwards and Gordon Rayner, ‘Jean Charles de Menezes inquest: Jury returns open verdict’ (The Telegraph, 12 December 2008) <www.telegraph.co.uknews>uknews>law-and-order> accessed 28 May 2020.

[318] The Telegraph, ‘Man shot by police outside Guildford Cathedral 'lawfully killed' (The Telegraph, 21 August 2009) <www.the telegraph.co.uk>news>uk_news>law-and-order> accessed 25 May 2020. [375] BBC News, ‘Kent robbery suspect “lawfully killed“‘ (BBC News, 25 January 2010) <www.bbc.co.uk_newsengland>kent> accessed 20 May 2020.

[319] BBC News, ‘Replica Uzi gun man “lawfully killed” by Kent Police ‘
(BBC News 1 March 2010). <www..bbc.co.uk>uk_news>england>kent> accessed 28 May 2020. [377] BBC News, ‘Woman shot. Dead by police lawfully killed, jury rules’ (BBC news, 29 April 2010) <news.bbc.co.uk>uk_news>England>kent> accessed 29 May 2020.

[320] Stephen Smith, *‘Stop! Armed Police!* (Robert Hale, 2013) 227,229.

[321] Sam Jones, ‘Mark Saunders was killed lawfully, inquest jury finds’ (The Guardian, 7 Oct 2010) <www.the guardian.com>oct>mark-saunders-inquest> accessed 27 May 2020.

No.	Name of deceased Coroner's region	Date of death Date of final hearing Length of hearing	Verdict
21.	Keith Richards County Durham & Darlington	12 May 2009 November 2011[322] 3 weeks	Lawful killing
22.	Michael Fitzpatrick Brighton and Hove	10 February 2011 January 2012[323] 1 week	Lawful killing

6.6 The remaining inquests of 2001 to 2012 - analysis

As the delays in holding the final hearing and concluding the inquest grew increasingly longer as demonstrated by the case studies, so the same delays to concluding these inquests can be seen in the other twenty-two inquests of this period. As a number of these deaths in this period occurred in highly controversial circumstances numerous reports on these inquests were available in the public domain.[324] Consequently, it is reasonable to assume that the coroner adopted the same practise of holding preliminary hearings and providing the early disclosure of evidence in these inquests as were adopted in the case studies in answer to the additional requirements imposed by Article 2.

6.7 Article 2, adversarialism and accountability

The inquests concluded in this second period of the research timeline saw increased delays, due to the requirements of Article 2 on all aspects of the investigation and inquest process, including the decision on whether or not to initiate criminal proceedings. These extensive delays were a source of dissatisfaction for the bereaved

[322] The Journal, 'Inquest finds Shildon man Keith Richards was lawfully killed by police' (The Journal, 8 November 2011) <www.thejournal.co.uk>News>North East News> accessed 29 May 2020.
[323] The Argus, 'Inquest into Brighton police shooting death' (The Argus, 27 January 2012) <www.theargus.uk.news-94980007.inquest-intr-bri accessed 28 May 2020.
See also; BBC News 'Lawful killing' verdict at Michael Fitzpatrick inquest' (BBC News, 3 February 2012) <www.bbc.co.uknews>uk_england_sussex-16875737> accessed 28 May 2020.
[324] Two of the most publicised inquests concerned the deaths of Harry Stanley who was fatally shot by firearms officer when a repaired wrapped table leg he was carrying home was mistaken for a gun. Jean Charles de Menezes was shot by firearms officers at Stockwell Underground Station after having been wrongly identified by police and mistaken as a terrorist.

family members and the firearms officers, some of whom remained suspended from an active role as an armed officer during the investigation process.[325] Lengthy delays

in concluding these inquests also had an adverse impact on the quality of evidence, the availability of witnesses and their ability to recollect events.[326]

Although an inquest made no provision for parties 'to put their case', bereaved families frequently sought to present alternative versions of the events. In several Article 2 inquests where the deceased had suffered with a mental health disability, scenarios put forward by the bereaved included a challenge to the planning command and control of the armed operation;[327] others bereaved families questioned why negotiators had not been used[328] and others queried why family members had not been permitted to speak to the deceased.[329] Coroner's decisions on verdicts to leave to the jury were also the subject of legal challenges by family members who sought a jury verdict of unlawful killing.[330] The representatives for bereaved families justified the extensive cross examination of police witnesses at the final hearing, as providing an answer to the defensive stance said to be routinely adopted by legal representatives for the police force and the armed officers and a lack of confidence in the ability of the coroner to robustly test the evidence of the police witnesses.[331] As a result, these contentious inquests routinely lasted weeks rather than the few days of the earlier period.

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[325] The primary armed officers in the shooting of Jean Charles de Menezes returned to active duty only after the inquest had concluded.
[326] The 2014 inquest of Dorothy Groce relied upon a 1987 report of the West Yorkshire Police, which had conducted an investigation in the shooting and had not previously been disclosed to the family. The former police officers who gave evidence were now elderly and long retired from the police service.
[327] Andrew Markland and Mark Nunes inquest files.
[328] Michael Fitzgerald inquest file.
[329] Mervyn Tussler inquest file
[330] Richard Edwards, 'Jean Charles de Menezes inquest: Family protest as jury sent out to consider verdict' (The Telegraph*,* 4 December 2008) <www.telegrah.co.uknews>Jean-Charlesde-Menezes-i> accessed 28 May 2020. In protest at the coroner's refusal to leave a verdict of 'unlawful killing' to the jury, family members of Jean Charles de Menezes stood up in front of the inquest jury and unveiled Tshirts displaying the message 'Your legal right to decide - unlawful killing verdict'.
[331] Elish Angiolini, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (HO 2017) p 203 para 16.56.

Where the death had occurred in the most contentious of circumstances family campaigns had often been set up after the fatal shooting with bereaved families openly calling for the armed officers to be prosecuted.[332] In the absence of a criminal prosecution the inquest provided the bereaved with the remaining public forum in

which to hear the full facts of their family member's death. The inquest also provided an opportunity to secure a verdict of 'unlawful killing', an outcome that was pursued by many families during this period, in the hope it would lead to a CPS review and reversal of the decision not to prosecute.

Despite the changes brought to these inquests by Article 2 and the opportunities provided to the bereaved to make informed challenges regarding the police evidence in respect of the planning, control and operational aspects of the fatal shooting, none of these inquests held during this period resulted in a verdict of 'unlawful killing'. In the absence of a criminal prosecution and with an inquest concluding with a verdict of lawful killing, some bereaved families continued their pursuit for justice and accountability through the domestic and European Courts in the hope that a criminal prosecution and conviction could be secured through ether through a second inquest and a verdict of 'unlawful killing'[333] or a decision that a failure to bring criminal charges against a firearms officer amounted to a breach of Article 2.[392]

6.8 Conclusion

[332] Derek Bennet, Harry Stanley and Jean Charles de Menezes family campaigns are all examples of this. BBC news 'Gunlighter man lawfully killed' (15 December 2004) <news.bbc.uk_news>england>london> accessed 2 August 2020. Harry Stanley was shot while carrying a wrapped table leg home after it had been repaired, which was mistaken for a gun after a call to the police by a member of the public. Jean Charles da Silva e de Menezes was fatally shot by MPS armed officers killed at the Stockwell underground station after he was mistakenly identified someone who had been involved in the previous day's failed bombing attempts.

[333] The first inquest into the 1999 death of Harry Stanley held in 2002 recorded an 'open' verdict. This verdict was subsequently quashed on the grounds that the inquest had failed to make sufficient inquiry into the circumstances of Mr. Stanley's death for the purposes of satisfying the requirements of Article 2. *Stanley, R(on the application of) v HMRC for Inner North London* [2003] EWHC 118 (Admin). [392] *Armani Da Silva v The United Kingdom* (application no. 5878/08) 30 March 2016.

The family of Jean Charles de Menezes efforts to pursue accountability through the criminal process took them to the ECtHR as they argued that the failure by the CPS to prosecute any individual officer amounted to a breach of the Convention.

Unlike the contentious inquests held during the 1990's the inquests concluded in this second period were significantly altered by the coming into force of the HRA. Article 2 brought with it several substantive benefits to the bereaved but also had an adverse impact on certain aspects of these contentious inquests. As the engagement of Article 2 to the state's obligations applied to all stages of the investigation of a police-shooting death and the CPS decision-making and review process, any delay to these being concluded adversely impacted upon the coroner's ability to proceed with and conclude the previously opened and adjourned inquest. As a consequence of delays, the preinquest review hearings, now routinely held by the coroner in response to the requirements of Article 2 often occurred at a time where the bereaved had waited years

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for a full explanation as to how their family member had died. Further, the resumption of the inquest signalled that there was to be no criminal prosecution of any firearms officer and that the justice and accountability sought by the bereaved in the form of a criminal prosecution was without more, unlikely to be realised.

The preparatory decisions which had previously been taken by the coroner with limited involvement of the interested parties, now habitually became more complex, as bereaved families sought to include in the inquest, several issues that were of concern to them. The practical steps that Article 2 required provided multiple opportunities for the interested parties to promote their opposing views on all issues relating to the holding of the inquest and to make legal challenges to the coroner's decisions when they viewed them as going against their interests. As a consequence, these matters contributed to the increasingly lengthy delays to the inquest being concluded which was now measured in years rather than the months of the previous period.

The disclosure of the documentary evidence to be used at the final hearing allowed the bereaved families and their legal representatives to extensively prepare for the inquest. Through extensive questioning of police witnesses, bereaved families hoped that the final hearing would reveal wrong-doing by the police body and its firearms officers, thereby substantiating their belief that their family member had been unlawfully killed at the hands of the state. Legal challenges to coroner's decisions before and during the inquest did little to allay the impression of a growth of an adversarial approach to these inquests, as each interested party sought to impose its

views and achieve their own frequently diametrically opposed objectives at every opportunity the inquest presented.

The information provided by the case studies and the remaining inquests of this second period, suggests that the coroner led inquests of the earlier period had been replaced by increasingly lengthy final hearings, with an adversarial approach to the questioning of witnesses, and one that sought to test the police officers' version of events, offer alternative versions of what had happened and to highlight what might have happened if different strategies had been used. As neither the coroner nor inquest jury possessed any powers to blame or punish any individual, the case studies revealed that the bereaved turned to a verdict of 'unlawful killing' as the means to achieve accountability and the hope that a criminal prosecution would result.[334]

Even as the coroner led inquisitorial inquests of the 1990's gave way to a seemingly more adversarial style in practice, the official view remained that public legal funding was not routinely required for the bereaved because of the inquisitorial nature of the inquest. This view of these inquests was not one that was uniformly shared by the bereaved or those representing their interests and did little to allay the families' perception of an inequality between them and the police body and its firearms officers in the lack of availability of legal funding.

As Article 2 became embedded in the inquest process during this period of contentious inquests, the inadequacies of the 1980's legislation that had remained in force during this period of inquests became increasingly clear to users of the coroner's court. The failure of this legislation to expressly promote or protect the interests of the bereaved or their participation in the inquest process that Article 2 required, contributed to the longstanding demands for a modernisation of the coronial service and the establishment of a national service that had been recommended in the Luce Review

[334] Jury's verdict of unlawful killing at inquest into the death of Ian Tomlinson vindicates family and public concern.' www.inquest.org.uk>ian-tomlinson-inquest-conclusion> accessed 10 September 2020. Although not a death that resulted from a police shooting, the death of Ian Tomlinson died after being struck by a police officer during the G20 demonstrations in April 2009. The CPS reviewed its decision not to prosecute the officer for manslaughter although the subsequent criminal trial ended in an acquittal. Peter Walker and Paul Lewis, 'Ian Tomlinson death: Simon Harewood cleared of manslaughter' (The Guardian, 19 July 2012) <www.the guardian.uk>jul>simon-harewood-not-guilty-i..> accessed 10 September 2020.

and the Smith Report. The effect of the resulting legislation in the form of the Coroners and Justice Act 2009 on the contentious inquests held in the third period of 2013–2018 is explored in the next chapter. However, due to the contemporary nature of these inquests and the likelihood of ongoing litigation access to the original inquest material was not sought. By continuing with the systematic exploration of the contentious inquests that were concluded in this third research period of 2013 to 2018, the changes brought about by the Coroners and Justice Act 2009 to the contentious inquests can be placed into context with those previously considered by this research.

CHAPTER SEVEN: THE CONTENTIOUS INQUESTS 2013 TO 2018

7.0 Introduction

The CJA received royal assent on 9 November 2009 and finally came into force on 25 July 2013 in respect of the coroner's jurisdiction having been delayed by the further consultation required by the UK government regarding the extent of the implementation of the Act. The long awaited reforms to the coronial legislation, had resulted in part from the fundamental problems with the coronial service identified earlier in the Luce and Smith reports but which had largely gone unaddressed by way of any substantial reform. Significant shortcomings identified in the coronal service were attributed to the absence of any clear statement of the rights of the bereaved and the lack of consistent standards in the treatment and support for all those who came into contact with coroners despite the increased expectations brought about by the engagement of Article 2. The CJA addressed these concerns by stating that its aim was 'to put the needs of bereaved people at the heart of the coroner system'.[335]

The absence of a national coroner's service had highlighted the inconsistency of approach by coroners to these contentious inquests across England and Wales and the significant differences experienced by the interested parties of the coroner's court.

[335] Ministry of Justice, Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009: Consultation on rules, regulations, coroner areas and statutory guidance (CP2/2013, 4) <consult.justice.gov.uk>coronerreformsconsultation> accessed 24 May 2020.

However, the CJA did not introduce a national coronial service but as an alternative, created the role of Chief Coroner. This role was created with the aim of providing supervision, guidance and leadership nationally to coroners and intended to provide users of the coroner's service, with a more professional and uniform approach to inquests. In the continuing absence of a national service, the role of Chief Coroner provided greater oversight of appointments of coroners and the CJA required regular mandatory training of coroners, thereby addressing a number of issues which had long been the subject of complaint.

The CJA also sought to distance itself from the adversarial sounding terms of and 'verdicts' and 'properly interested parties' by replacing them with the terms

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'determinations' and 'properly interested persons'.[336] However, the CJA retained the use of the short-form conclusion of unlawful killing with its requirement of a criminal standard of proof together with the previous prohibition on naming or attributing blame to any individual in the inquest conclusions.[337] The provisions originally included in the CJA had created an internal right of appeal to the Chief Coroner although this appeal route was effectively abandoned before the Act came into effect, thereby preserving the judicial review as the forum in which to challenge the coroner's decisions or inquest conclusion.[338]

In the enactment of this legislation, the CJA placed on a statutory basis the changes Article 2 required to the contentious inquests. This legislation included the mandatory requirement of disclosure of evidence, thereby removing this issue from the coroner's exercise of discretionary powers.[398] Provision was also made for and encouraged by

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[336] Coroners and Justice Act, s 9 and s 47.
[337] Coroners and Justice Act 2009, s 5(3).
[338] Coroners and Justice Act, s 40. In the initial form of the 2009 Act, this section provided a right of appeal to the Chief Coroner against certain decisions of a coroner. This route of appeal was new and it enabled aggrieved interested persons to appeal directly to the Chief Coroner without having to use the expensive and legally complex rout of judicial review. A section 40 (appeal) decision of the Chief Coroner could then be appealed to the Court of Appeal, on a point of law only. However, this statutory route of appeal never came into force. It was repealed by the Public Bodies Act 2011, before other provisions of the Coroners and Justice Act 2009 came into force, [398] Coroners (Inquests) Rules 2013, r 13.

the Chief Coroner, the holding of preliminary hearings as the means by which coroners and interested persons could comprehensively prepare for complex inquests.[339]

Therefore, the changes brought about by the CJA removed two important issues from the inconsistencies of approach coroners had previously demonstrated and intended to improve access to and participation of the bereaved in the inquest process. This chapter considers how these statutory changes affected the contentious inquests that were concluded in the period 2013 to 2018 and whether the adversarial approach of the previous period was lessened by the reforms introduced by the modernising legislation of the CJA.

7.1 The inquests

On 25 July 2013, the CJA together with the necessary secondary legislation dealing with the inquest and investigation rules came into effect in England and Wales.[340] From this date, all inquests became subject to the new regime although any decisions the coroner had made in respect of ongoing inquests opened under the previous legislation remained valid. Consequently, the contentious inquests that were held during the period 2013 to 2018 were subject to the provisions of the 2009 Act, which provided legislation that ensured the inquests were Article 2 compliant. Due to the legislative changes and the guidance provided by the Chief Coroner on matters of law and procedure the contentious inquests that were concluded during this period demonstrated a greater degree of consistency of approach by coroners.

During the period of 2013 to 2018 there were eighteen fatal police-shooting inquests opened by the coroner in whose jurisdiction the death had occurred, although one of which was converted at a late stage to a Public Inquiry which is still to be held.[341] Of

[339] Coroners (Inquests) Rules 2013, r 6 makes provision for the holding of pre-inquest review hearings. Although, non-mandatory, the Chief Coroner's Guidance: No. 22, encourages coroners to hold these preliminary hearings for better management of the inquest.

[340] The Coroners (Inquests) Rules 2013 and The Coroners (Investigations) Regulations 2013 also came into force on 25 July 2013.

[341] Home Office: Establishing a public inquiry into the death of Jermaine Baker (HLWS104, February 2020) <www.parliament.ukpublications>Lords>HLWS104> accessed 24 May 2020. The inquest of

the seventeen remaining inquests, thirteen were concluded in this period in which the jury in twelve of these reached a conclusion of, or one that equated to, a determination of lawful killing. One inquest concluded with a narrative conclusion in which the jury made findings that were of critical of police actions. The remaining four inquests are yet to be concluded with delays of two to four years having been accumulated. Although, original inquest materials were not accessible in respect of most of these inquests the more recent nature of these deaths, as well as the increase in publicly available official material, provided sufficient details to compile a summary of them in in the same format as used in the previous chapters as set out in Table 8.

Table 8: Contentious inquests 2013 to 2018

No.	Name of deceased Coroner's area	Date of death Date of final hearing Length of hearing	Outcome
1.	Mark Duggan North London	4 August 2011 September 2013[402] 4 months	Lawful killing
2.	Alistair Bell West Yorkshire (Western)	28 December 2010 January 2014[342] 3 weeks	Narrative (shooting justified)
3.	Dorothy Groce Inner London South	24 April 2011 June 2014[343] 2 weeks	Critical narrative
4.	Dean Joseph North London	5 September 2014	Lawful killing (with critical narrative of police

Jermaine Baker was converted to a public inquiry to allow a wider investigation to be conducted and is still to be heard.

The other inquest converted to a public inquiry this period concerned the death of Anthony Grainger and concluded in 2019.

[342] Louise Cooper, '"Police marksman's shots were justified" - jury record narrative verdict in Alistair Bell inquest' (ExaminerLive Yorkshire, 29 January 2014) <www.examinerlive.co.uk>News>AlistairBell>accessed 24 May 2020.

[343] Original inquest file of Dorothy Groce.

		July 2015[344] 3 weeks	
5.	James Fox North London	30 August 2015 September 2016[345] 5 weeks	Lawful killing
6.	Richard Davies Cambridgeshire and Peterborough	21 October 2015 July 2017[346] 2 ½ weeks	Lawful killing
7.	James Wilson Newcastle upon Tyne	1 April 2016 November 2018[347] 3 weeks	Lawful killing
8.	William Smith North West Kent	1 May 2016 Not yet held[348] 6 weeks (estimated)	TBD

[402] HHJ Keith Cutler, '*Inquest Into the Death of* Mark Duggan - *Report to Prevent Future Deaths',* (HM Coroner for North London, 2014) < www.judiciary.uk>2014/06>Duggan-2014-0182> accessed 24 May 2020.
The inquest into the death of Mark Duggan lasted for four months but included a break over the Christmas and New Year period with the jury returning to give its conclusion in January 2014.

No.	**Name of deceased Coroner's area**	**Date of death Date of final hearing Length of hearing**	**Outcome**
9.	Josh Pitt Bedfordshire and Luton	9 November 2016 January 2019[410] 1 week	Lawful killing
10.	Lewis Skelton East Riding and Hull	29 November 2016 Not yet held [411] TBD	TBD
11.	Yasser Yakub West Yorkshire (Western)	2 January 2017 Not yet held[412] TBD	TBD

[344] Emma Youle, 'Dean Joseph inquest: Met Police "regrets" killing of Islington man in hostage siege' (Islington Gazette, 13 August 2015) <www.islingtongazetter.co.uknews>crime-court>dea...> accessed 15 October 2020.
[345] BBC news, 'James Fox father "disappointed" with lawful killing ruling' (BBC news online 23 September 2016) <www.bbc.co.uk-england-london-37455703> accessed 24 May 2020.
[346] Anna Savva, '"Lawful killing" verdict returned in inquest into county's first fatal police-shooting' (Cambridgeshire News, 21 July 2017) www.cambridgeshire-news.co.ukNews>Cambridgeshire.News> accessed 24 May 2020.
[347] Sonia Sharma and Kathryn Riddell, 'Police shooting inquest: Updates from three-week hearing and verdict on James Carlo Wilson's death' (ChronicleLive South Shields, 27 November 2018) <www.chroniclelive.co.ukSouth Shields> accessed 24 May 2020.
[348] The final hearing into the death of William Smith has not yet been held although the coroner's website for North West Kent lists the final hearing date as 2 November 2020 for nearly six weeks.

12.	Khalid Masood Inner London West	22 March 2017 November 2018[413] 1 week	Lawful killing
13. 14. 15.	Khuram Butt Rasheed Redouane Zaghba Youssef Inner London South	3 June 2017 July 2019[349] 2 weeks	Lawful killing
16.	Spencer Ashworth Avon	27 September 2017 March 2020[350] 2 weeks	Lawful killing
17.	Richard Cottier East London	9 April 2018 Not yet held[416] TBD	TBD

[410] BBC news, 'Josh Pitt: knifeman shot by police gunman lawfully killed' (BBC online news, 14 January 2019) < www.bbc.co.uk>news>uk-englad-beds-bucks-herts-> accessed 24 May 2020.

[411] The inquest of Louis Skelton is currently being delayed pending further clarification from the Supreme Court on the standard of proof required for a conclusion of "unlawful killing" in an inquest. It was decided in the High Court and confirmed in the court of Appeal in *R (Maughan) v. HM Senior Coroner for Oxfordshire* [2018] EWCA Civ 809 that the standard of proof required for a conclusion of "suicide" was the civil standard rather than the previously applied criminal standard as currently required for a conclusion of 'unlawful killing'.
This has been further delayed due by the decision of the Supreme Court in the case of *Maughan* where the standard of proof required for the short form conclusions of "suicide" and "unlawful killing" in an inquest are to be decided, *R(Maughan) v HM Senior Coroner for Oxfordshire* [2019] EWCA Civ 809.

[412] The final hearing was delayed by the criminal trial of alleged accomplices, which concluded in June 2019. The IOPC has now completed its report, but the inquest has been further delayed due to the closing of the coroner's court as a result of the restrictions imposed by the coronavirus pandemic 2020.

[413] "The Westminster Bridge attack". This inquest was heard immediately after the inquests of Khalid Masood's five victims.

7.2 Case studies

Due to the ongoing nature of a number of these contentious inquests, the possibility of a review by the CPS after an inquest has concluded and the potential for civil litigation, access to original file material for these inquests was generally not available.[351] Therefore, the case studies focus upon a few of the most contentious inquests that were

[349] 'The London Bridge Attack'. These inquests were heard together as they arose out of the same "terrorist" incident in which they had all been involved and during which they were fatally shot by armed officers after their attack on members of the public in and around London Bridge. The three inquests were held immediately after the inquests of their eight victims had concluded by the Chief Coroner <www.londonbridgeinquests.independent.gov.uk/inquests> accessed 24 May 2020.

[350] Ellena Cruse, 'Man shot dead by police posed 'immediate threat to life' after firing air pistol, report finds' (Evening Standard, 17 March 2020)< www.standard.co.uk.newsUK> accessed 20 October 2020.

[416] As of April 2020, the IOPC was still investigating the fatal shooting of Richard Cottier.

[351] With the exception of the inquest file of Dorothy Groce where the shooting had taken place in 1985 the injuries from which were attributed to Mrs Groce's death in 2011..

held in this period using a combination of official transcripts, original file material and a public meeting of an ongoing family campaign.

7.2.1 Mark Duggan[352]

On 4th August 2011, Mark Duggan was fatally shot by firearms officers in a planned police operation as he emerged from a taxi as it was believed he was in possession of a firearm. Mr Duggan's controversial death led to rioting in areas of London and other major cities in the UK.

Due to the confidential nature of certain evidence that was not permitted to be disclosed to a coroner, a judge was appointed to lead the inquest. Although the inquest had commenced under the 1980's coroner's legislation, the inquest became subject to the provisions of the CJA as it had not been completed before the implementation of the Act on 25th July 2013. In compliance with Article 2 preparation for the inquest involved multiple pre-inquest review hearings and the disclosure of evidence to all interested parties was provided. Following a delay of two years, the final hearing began in September 2013 and held over a four-month period.[353] The inquest concluded with the jury's determination that Mr Duggan had been lawfully killed having also been left with the alternatives of unlawful killing and open to consider by the coroner. This conclusion was met with anger by the family of Mr Duggan and

unsuccessfully challenged in a judicial review in the High Court and Court of Appeal.[354]

[352] Keith Cutler HHJ, 'Inquest into the death of Mark Duggan, Report to Prevent Future Deaths (29 May 2014). This report provides details about the management of the inquest and includes the conclusions that were left to the jury < www.judiciary.uk>2014/06>Duggan-2014-0182> accessed 6 September 2020.

[353] Coroners (Inquests) Rules 2013, r 3. By reason of the timing of the death and the date of the final hearing, this inquest was conducted under the provisions of the 2009 legislation as the CJA applied to all inquests that had not been completed by 25 July 2013, although all decisions made under the 1988 Act remained valid.

[354] *R (Pamela Duggan) v HM Assistant Deputy Coroner for the Northern District of Greater London* [2017] EWCA Civ 142. The decision of the High Court was confirmed after a full hearing by the Court of Appeal and subsequently was refused to be considered by the Supreme Court as not raising an arguable point of law.

In spite of these unsuccessful challenges to the inquest conclusion and the subsequent settlement of a civil suit for damages, the family and supporters of Mr Duggan have continued to campaign for 'Justice for Mark'. In their efforts to seek to quash the findings of the inquest, the campaign has sought new evidence on which to base an application for a second inquest. This evidence has included a forensic modelling of the moments before Mr Duggan's fatal shooting based solely on the evidence given at the inquest and which is said to undermine the jury's findings and conclusion.[355]

7.2.2 Dorothy Groce[356]

Dorothy 'Cherry' Groce was shot in her home on 28th September 1985 by armed police officers looking for her son who was suspected by the Hampshire Constabulary of being in possession of a firearm from an incident that had occurred earlier in its jurisdiction. Although the shot fired by the police officer that struck Mrs Groce did not prove to be fatal, it left her permanently paralysed. The pathologist attributed Mrs Groce' death on 24th April 2011 to have been substantially caused by the injuries received as a result of the gunshot fired by a police officer during the police operation. After the police operation, a referral was made to the Police Complaints Authority and the West Yorkshire Police were requested to conduct an investigation which was concluded by a report in 1987.

Before the inquest, this report had not been previously disclosed to the family of Mrs Groce or its findings publicly accepted by the Metropolitan Police Service. On the morning of the first day of the final hearing held in 2014, the MPS openly accepted

the findings of this report, including the findings of failings it had identified in the police operation. Despite this late admission the inquest proceeded as scheduled.

[355] At a public meeting held on 16 December 2019 by the family campaign 'Justice for Mark Duggan' a modelling of the moments immediately leading up to his shooting was presented by the research group Forensic Architecture (Goldsmiths University). This modelling was based solely on the transcripts of evidence from the inquest showing the movements of Mr Duggan and his ability to have thrown the gun to the place where it was found before being shot by the armed officers who confronted him immediately after the taxi was forced to a hard stop.

[356] Original inquest file of Dorothy Groce accessed at Inner South London Coroner's Court 2019.

The complexity of the factual and legal issues arising from an act carried out in 1985, the acquittal of a police officer in 1987 of charges of causing bodily harm and Mrs Groce's death in 2011 required the holding of multiple preliminary hearings. These included issues of ambit, evidence, witnesses, the location and length of the final hearing. Another significant source of delay in the preparation of and holding of the final hearing was the lack of public legal funding for the bereaved family, without which they were unable to participate in their mother's inquest. After nearly a year of delays, legal funding was eventually secured and the inquest went ahead nearly twenty-five years after the initial shooting and three years after Mrs Groce's death.

An Article 2 compliant inquest was held under the provisions of the Coroners and Justice Act 2009 in which the interested persons included the family, the MPS and the Hampshire Constabulary and several of the police officers including PC Lovelock who had taken part in the armed operation. The ambit of the inquest primarily concerned the events of the evening of Mrs Groce's shooting in 1985 with some evidence heard in respect of the earlier incident concerning police officers from Hampshire.[357] The inquest relied heavily upon the evidence contained in the 1987 report as well as oral evidence from several of the long retired police officers who had taken part in the 1985 police operation.

At an earlier preliminary hearing it had been agreed by all legal representatives, including those for the family, that a conclusion of 'unlawful killing' could not be left with the jury. [358]. As an alternative, the jury was asked to consider reaching a narrative conclusion based on its findings to a number of questions compiled and agreed between the coroner and the legal representatives for the interested parties. In making

its findings and reaching its conclusions, the jury was required to consider the standards of armed policing that applied in 1985 and were prohibited from applying

[357] The Hampshire Constabulary had been involved in a recent earlier incident concerning Michael Groce in which a firearm was alleged to have been in his possession and which led to the search of Mrs Groce's home.

[358] In the course of a preliminary the application of a 'year and a day' and 'double jeopardy' were considered. Criminal Justice Act 2003 Part 10. This Act reforms the law relating to double jeopardy, by permitting re-trials in respect of a number of very serious offences, where new and compelling evidence has come to light.

modern standards of policing retrospectively or from making determinations with the benefit of hindsight. The jury returned a critical narrative conclusion that included findings of several failings in the police operation. Due to the historical nature of these events a report on action to prevent further deaths was not written.

7.2.3 Khalid Mosood

On 22nd March 2017 Khalid Mosood attacked and killed four members of the public and PC Palmer an on duty police officer, during which he was fatally shot by a plain clothes close protection officer. The coroner for Inner London West opened inquests into all six deaths which were subsequently transferred to the Chief Coroner for management and hearing. After several preliminary hearings, the Inquests of the five victims of the attack were held together in November 2018 without the presence of a jury and concluded with a determination of unlawful killing. Immediately afterwards, a final inquest hearing into the death of Mr Masood was held with a jury over a period of one week. The inquest ended with a conclusion of lawful killing on the direction of the Chief Coroner. After the inquest, the Chief Coroner wrote a report on action to prevent future deaths after a finding that PC Palmer could have been saved if the MPS had posted armed officers at the entrance to the Palace of Westminster.

7.3 Summary of inquests 2013 to 2018

The third period illustrates the significant changes the 2009 Act brought to these contentious inquests all of which required the holding of preliminary hearings and the pre-inquest disclosure of evidence with the bereaved legally represented at the inquest. During this period, the delay to the holding of a final hearing had not noticeably decreased and for some inquests this delay in became significantly longer. In addition, the increased complexity of these inquests was reflected in the length of the final hearing which extending over weeks and on occasion, to several months.

Table 9: Summary of inquests 2013 to 2018

[359] No.	Name of the deceased	Time taken between death and	Preliminary hearings held	Disclosure of evidence	Legal representation of family
1.	Mark D uggan[425]	**final** 2 years	Yes	**to** Yes**family**	Yes
2.	Alistair Bell [426]	4 years	Yes	Yes	Yes
3.	Dorothy Groce [360]	3 years	Yes	Yes	Yes
4.	Dean Joseph[361]	10 months	Yes	Yes	Yes
5.	James Fox [362]	1 year	Yes	Yes	Yes
6.	Richard Davies	2 years	Unknown	Unknown	Unknown
7.	James Wilson	18 months	Unknown	Unknown	Unknown
8.	William Smith	4 years (continuing)	_	_	_
9.	Josh Pitt [363]	2 years	Yes	Yes	Yes
10.	Lewis Skelton	3½ years (continuing)	**–**	**–**	**–**
11.	Yasser Yakub **431**	3 years (continuing)	_	_	Yes

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[359] Louise Cooper, 'Gunman's taunts to officer who shot him' (YorkshireLive, 21 January 2014) <www.examinerlive.co.uk. . .>Bradford Crown Court> accessed 11 September 2020.
[360] Original inquest file of Dorothy Groce.
[361] Bindmans solicitors, 'Anonymity for firearms officers refused in the Dean Joseph inquest' <www.bindmans.comnews>anonymity-for-mps-fireatms. . .> accessed 11 September 2020.
See too; Police Professional, 'Family loses case against MPS over son who was shot dead by officer. <www.policeprofessonal.comnew>family-loses-case> accessed 11 September 2020. A subsequent claim for damages brought on behalf of Mr Joseph's estate was dismissed with the judge commenting that the officer should be commended for his actions.
[362] INQUEST, 'Inquest into the fatal shooting of James Fox by Metropolitan Officers concluded' (INQUEST 23 September 2016) <www.inquest.org.ukjames-fox-inquest-closing> accessed 11 September 2020.
[363] INQUEST, 'Inquest concludes fatal shooting of Jodh Pitt by Bedfordshire police was "lawful killing"' <www.inquest.org.ukinquest-concludes-fatal-shooting> accessed 11 September 2020. [431] Martin Shaw, 'The battle begins now" says Yassar Yaqub's dad as police probe ends' (ExaminerLive, 31 December 2018*)* <www.examinerlive.co.ukNews>Crossland Moor< accessed 24 May 2020. The family want the jury inquest to prove their family member was unlawfully killed by police and intend to be legally represented at the inquest.
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[425] HHJ Keith Cutler, 'Inquest into the death of Mark Duggan, Report to Prevent Future Deaths' (29 May 2014). This report provides details about the management of the inquest as includes the conclusions that were left to the jury <www.judiciary.uk>2014/06>Duggan-2014-0182> accessed 11 September 2020.

No.	Name of the deceased	Time taken between death and	Preliminary hearings held	Disclosure of evidence	Legal representation of family
12.	Khalid Masood [364]	**final** 18 months	Unknown	**to** Unknown**family**	No
13.	Khuram Butt[365] Rasheed Redouane Zaghba	2 years	Yes	Yes	Yes
14.	YoussefSpencer Ashworth	$2^{1/2}$ years	Unknown	Unknown	Unknown
15.	Richard Cottier	2 years (continuing)	–	–	–

This period of contentious inquests also saw several high profile inquests being judge led, either by the Chief Coroner or by the appointment of a High Court Judge as an assistant coroner, for the specific purpose of conducting a particularly sensitive or complex inquest, or one in which part of the relevant evidence could not be disclosed to a coroner. These inquests included those of Mark Duggan, Khalid Masood, Khuram Butt, Rasheed Redouane and Zaghba Youssef. Although initially intended to be heard as judge led inquests, the investigations into the death of Anthony Grainger and Jermaine Baker were converted to public inquiries.[434]

[364] Although the family of Khalid Masood previously had legal representation, they did not actively take part in the final hearing.

[365] An official link to the inquest proceedings in inquests of those who died in the London Bridge attack was established. <www.londonbridgrinquest.independent.gov.uk> accessed 11 September 2020. This provides an official link to the inquest proceedings in respect of the victims and the three attackers.

[434] House of Commons, *'The Anthony Grainger Inquiry: Report into the Death of Anthony Grainger,* (HC 2354, 2019,) < www.gov.uk/official-documents> accessed 24 May 2020.

The Report of the Inquiry into the death of Anthony Grainger emphasised the obligation of the state to make sufficient inquiries to satisfy Article 2 requirements of rigorous and independent inquiry into the use of fatal force by police officers. Where, the surviving documentary record was neither complete nor uniformly reliable, only the most searching examination of what remains, and of witnesses' oral testimony, had any chance of getting at the truth. The inquiry report exposed many material facts and grounds for serious criticism of the Greater Manchester Police that an earlier examination by the Independent Police Complaints Commission had failed to uncover.

7.4 Legal funding

The lack of an automatic grant to legal funding for the bereaved families, either in the most contentious of inquests and in other circumstances where Article 2 was engaged

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was continued in the CJA. In its final review of legal aid for inquests, the government repeated its long held view that the majority of inquests were conducted in an inquisitorial style and the bereaved did not require legal representation.[366] The review expressed some concerns, that in the most contentious inquests, proceedings could become adversarial with some lawyers demonstrating inappropriate behaviour in their approach to these inquests and their style of advocacy.[367] However, the review emphasised that inquests should remain inquisitorial. This could by ensuring that coroners were equipped to control inquest proceedings and that the lawyers appearing before them understood both how an inquest should work and what was expected of them and their style of advocacy in an inquisitorial forum. As a result of this review, it was concluded that automatic legal funding for the bereaved in these contentious inquests was unnecessary and therefore it should remain unavailable to the bereaved except in exceptional circumstances.

Consequently, during this period of contentious inquests, the bereaved as interested persons, remained required to satisfy the criteria under the Exceptional Funding Provisions for Inquests, in order to be legally represented at the inquest of their family member, unless they could rely on private funds.[368] The government view remained that as the inquest was inquisitorial the bereaved or the coroner on their behalf could ask all the relevant questions addressing their concerns without the need for legal representation. The final review also recognised the right of public bodies and individuals working within them to have legal representation, as it was likely that this provision formed part of their conditions of employment.[369]

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[366] Ministry of Justice, *'Final report: Review of legal aid for inquests,* (CP 39, 2019) 7.
[367] Ministry of Justice, *'Final report: Review of legal aid for inquests,* (CP 39, 2019) ch 3.
[368] INQUEST, 'Cherry Groce inquest: family statement in full' (10 July 2014). At the inquest of Dorothy Groce, the bereaved family were repeatedly refused legal funding and resorted to compiling a public petition seeking an award of public funding which was finally secured. <www.inquest.org.ukcherrygroce-inquest-family-stat> accessed 30 July 2020.
[369] Armed police officers are often provided with individual legal representation from the Police Federation of England and Wales if their interests are not wholly aligned with those of their employer. <www.polfed.org> accessed 30 July 2020.

However, the effect of this lack of legal funding has been to continue the existing perception of an unfair imbalance between the number of legal representatives for the police authority ad its officers and those acting on behalf of the family. The issue of funding for legal representation at inquests has remained a source of great concern and

has drawn support from a range of bodies, including coroners and the new body created to conduct independent investigations into police shootings, the Independent Office for Police Conduct, (IOPC).[370]

The widespread support for legal funding for the bereaved recognised the legal and factual complexity of these contentious inquests and the daunting if not impossible hurdle they presented to the bereaved during a period of great emotional distress and in the unfamiliar and intimidating surroundings of the coroner's court.[440] Despite the restrictions placed on the provision of legal funding, the bereaved were frequently legally represented in the inquests held during this period.

7.5 'Unlawful killing' and the standard of proof

The inquest into the fatal shooting of Lewis Skelton was adjourned by the senior coroner pending a decision by the Supreme Court as to the standard of proof that is required at an inquest for a determination of 'suicide' and by extension 'unlawful killing'.[371] Previously, the standard of proof for both of these inquest verdicts or conclusions has been that utilised in criminal proceedings of beyond reasonable doubt. However, the Court of Appeal decided that the civil standard of proof applied in

[370] IOPC: 'Consultation response regarding legal representation for families at inquests' (August 2018). The IOPC stated that it has for some time, supported calls for free legal representation for bereaved families where there has been a death following police contact.
www.policeconduct.gov.uk › files › research-learning <accessed 21 September 2020>. [440]
INQUEST, 'Now or Never! Legal aid for inquests' (2019) <www.inquest.org.uk >legal-aid-for-inquests>st.org.uk › accessed 15 May 2020.
The Angiolini report and most recently the IOPC have indicated support for the grant of automatic public legal funding for Article 2 inquests.

[371] The inquest of Lewis Skelton remains adjourned until the Supreme Court delivers its pending judgement on the use of the criminal standard of proof in inquests in respect of the use of 'suicide' and 'unlawful killing' conclusions. The Supreme Court considered whether the legal, practical and policy reasons on whether the criminal standard 'beyond reasonable doubt' or the civil standard 'on the balance of probabilities' s hould apply to suicide and unlawful killing conclusions. Whereas both had previously applied the criminal standard of proof the Court of Appeal decided that it was the civil standard that should be applied to suicide and made obiter marks in respect of the standard of proof required in inquests for a conclusion of 'unlawful killing'. *R(Maughan) v HM Senior Coroner for Oxfordshire* [2019] EWCA Civ 809.

inquests for conclusions of suicide and indicated that the same civil standard should apply for a determination of unlawful killing in an inquest. The decision of the

Supreme Court was published on 13th November 2020 in which it determined than the civil standard of proof should apply to an inquest conclusion of 'unlawful killing.'[372]

7.6 The Independent Office for Police Conduct

The IOPC was created in January 2018, to replace the Independent Police Complaints Commission (IPCC) which had been heavily criticised by many stakeholders for its apparent bias in favour of police authorities and its officers as well as the delay in completing its investigations. The creation of the IOPC has been intended to deliver speedier decision-making under new leadership and to ensure greater transparency and accountability to the public by being given wider powers than its predecessor, which include having the authority to conduct investigations without the need for a referral from a police body. Although still a relatively new organisation, concerns were raised that the new system of investigation of police conduct was not working as had been anticipated. Consequently, an inquiry was launched in the House of Commons to examine the role and remit of the IOPC within the police conduct and discipline system and its powers and effectiveness.[373]

7.7 Delays, inquest conclusions and accountability

Despite the modernisation of the coronial service the CJA has not proved successful in reducing the long delays that occurred in concluding these contentious inquests. Although provision has been made in the legislation requiring (routine) inquests to be concluded within six months of the death being reported to the coroner, a reporting

[372] *R (Maughan) v Her Majesty's Senior Coroner for Oxfordshire* UKSC 2019/0137. The impact of this decision on inquests into police-shooting deaths has yet to become clear as the civil standard of proof has yet to be applied to a finding of unlawful killing.

[373] The House of Commons Home Affairs Committee launched an inquiry into police conduct and complaints, 28 October 2019 <www.parliament.uk> business>news>parliament-2017> accessed 8 September 2020.

provision has also been included for complex deaths which have exceeded a twelvemonth period.[374] Although delays have resulted from matters not within the coroner's control and included the completion of reports by the investigating body, the CPS decision making and the difficulty experienced by the bereaved in obtaining legal funding, other reasons for delay have been attribute to the time taken to hold multiple

preliminary hearings, the availability of the coroner to hear these complex inquests and a suitable venue in which to hold a lengthy final hearing.

While the engagement of Article 2 and the CJA has had a significant impact on the ambit and conduct of these contentious inquests as well as the involvement of the bereaved, it has had little impact on their outcomes. The contentious inquests held in this period have demonstrated that the modernisation of the coronial service to accommodate the requirements of Article 2 has not provided an outcome of unlawful killing even where the death has occurred in the most contentious of circumstances. For a number of bereaved families, the inquest has failed to provide the accountability they sought in the form of an unlawful killing conclusion and a criminal prosecution of a firearms officer for murder or manslaughter.[375] In the absence of any criminal prosecution families of the deceased have had to turn to the civil courts to claim damages as the only means available to hold officers and their police employers to account.[446]

To secure a greater number of 'unlawful killing' determinations at an inquest, the interest group INQUEST has suggested that an amendment to the law of self-defence is required, whereby a firearms officer must establish that not only did they hold a belief that the deceased presented a physical threat but also the belief was reasonably held. It is suggested this amendment should replace the honest but mistaken belief defence frequently heard during these inquests. However, such a course of action is

[374] The Coroners (Inquests) Rules 2013 r 8, see also Coroners and Justice Act s 16.

[375] In 2019 a civil claim for damages in which, the court would have had to examine whether Mark Duggan was holding a gun or had thrown it away before being shot and whether V53 had a 'reasonable belief that Mr Duggan was holding a gun when he was shot' was settled in a confidential agreement. [446] The children of Dorothy Groce have sought and received a payment of damages for their continuing losses. However, the 2018 damages claim brought by the family of Dean Joseph was refused by the court and the police officers were commended by the judge for their actions. The family of Mark Duggan settled a claim for damages with the MPS in 2019.

unlikely to generate a flood of criminal prosecutions even if it resulted in more unlawful killing inquest conclusions, in view of the more stringent rules on the admissibility of evidence in the criminal court. Therefore, such reform may serve to amplify the gulf between the inquest and potential for a criminal outcome rather than narrow it.

7.8 Conclusions

The contentious inquests that were concluded in this third period of research recognised the rights of the bereaved by implementing the requirements of Article 2 placed on a statutory footing by the provisions of the CJA. The newly created post of Chief Coroner had also provided national oversight and guidance to coroners in the form of Law Notes and Guidance Sheets to an otherwise continuing locally provided service to ensure the provision of a more uniform and professional approach

As Article 2 became embedded into every aspect of the investigation into the fatal police shooting, contentious inquests throughout this third period continued to be subject to delays that could frequently be measured in years. Final hearings became more lengthy and routinely lasted weeks, as families took the opportunities afforded by Article 2 to actively challenge the official version of events. The complexity and sensitivity of the evidential material required for the final hearing in several of these inquests has led to their being transferred to the Chief Coroner or a specially appointed High Court judge. These appointments have done little to reduce the delays to the holding of the final hearing or the time required to conclude them.

This chapter has sought to address the effect that Article 2 has continued to have on these contentious inquests in the form of the now routinely held preliminary hearings and the mandatorily required disclosure of evidence. Although, the modernising legislation of the CJA has replaced adversarial sounding language with more neutral terms these contentious inquests have, as in the previous period, showed few signs of reverting to the coroner led inquests of the 1990's. Instead, the measures implemented by the coroner in answer to the investigative obligations imposed by Article 2 have lengthy final hearings that have been approached as an adversarial hearing which have

nonetheless failed to conclude with a determination of unlawful killing. The growing adversarialism in these inquests was recognised in the 2017 independent Angiolini report by as being the reality, despite the continuing lack of recognition of this by the courts and other official bodies.

Having considered the questions posed by this thesis from a quantitative orientated perspective, the next chapter adopts a qualitative approach to the questions asked by this thesis with interviews with firearms officers and lawyers who have developed expertise in providing representation at these contentious inquests.

CHAPTER EIGHT: THE INTERVIEWS

8.0 Introduction

The difficulties with research on the subject of death investigation and more particularly, where a death had occurred after state involvement have previously been identified.[376] This became increasingly apparent at the qualitative stage of this research when interviews were sought from firearms officers, lawyers, the bereaved and interest groups. Ethics approval was sought and granted for interviews and information on the process and consent forms were provided to the participants.

The interviews with lawyers who had represented the differing interests and concerns of the interested parties and persons were expected to provide a divergent but valuable perspective and insight into the impact of Article 2 on these contentious inquests. In deciding which lawyers to interview it was possible to ascertain their identities from a number of sources which included inquest files and media reports as well as in some instances, law reports where challenges to the inquest had been made. As a consequence of the specialist nature of the inquisitorial forum, a relatively small and identifiable number of lawyers with expertise in representing the interests of specific groups in these contentious inquests had developed. From these sources it was possible to identify the professional address of these lawyers and where a request for an interview could be sent. These requests met with varied responses or more commonly no response at all, although a small number of lawyers with considerable experience between them that covered all three periods of the timeline, agreed to participate in an interview for this research.

Gaining access to the firearms officers raised a particular challenge. Having been granted anonymity by the coroner, the identity of these firearms officers was mostly unknown in the inquest at which they had given their evidence. Although requests were made to each relevant police authority that was located in the coroner's jurisdiction identified in the previous chapters, most of these either went answered or

[376] David Baker, 'Researching deaths after police contact: challenges and solutions (2016) 2(1) Journal of Criminological Research, Police and Practice 15.

were refused outright with no reason being provided. However, contact with the Police Firearms Officers Association (PFOA) to which many of the firearms officers belonged, met greater success, as the interview request was circulated among its members, thereby allowing individual officers to initiate contact if they were willing to participate in an interview.[448] It was anticipated that the views and opinions of authorised firearms officers who had been involved in these contentious inquests would provide a unique perspective and one that was less likely to have been widely publicised due to the nature of their role.

8.1 The authorised firearms officers [449]

For each authorised firearms officer the decision to discharge their firearm remained at all times during the armed operation, their sole responsibility and for which, they alone were answerable. After each fatality, the firearms officer concerned had been called upon to account for their actions to the independent investigators and at the inquest that had followed. At each of these stages, the firearms officers had been entitled to rely upon the same criminal law defences as applied to any other person in similar circumstances.

A number of positive responses to a research request made to the Police Firearms Officers Association secured the majority of these interviews with one former firearms officer being approached through their publisher. All the firearms officers who responded to the request for an interview spoke on the assurance of confidentiality as they had previously been provided with anonymity by the coroner in the inquests at

[448] Police Firearms Officers Association. The PFOA was created in 2009 to support all those involved in firearms operations and their families.

[449] Home Office, ‘Police use of firearms statistics’ (2019) <www.gov.uk > Crime, justice and law>Policing>accessed 11 August 2020. An AFO was defined in the official gathering of statistics in England and Wales until March 2017 as ‘a police officer who has been selected, trained, accredited and authorised by their Chief Officer to carry and use a firearm.’ In this thesis the term ‘AFO’ is used to refer to a police officer trained at the basic level as well as to any firearms officer in general. Historically, there have been a number of names given to various units in which firearms officers have been employed by different forces. However, it is not necessary to distinguish between them for this research and therefore, the use of the term Authorised Firearms Officers includes all police firearms officers who had been involved in these police shootings.

which they had appeared. The interview that was held comprised structured questions with an opportunity to make any further comment in order to obtain an insight into how they viewed these contentious inquests.

The accounts provided by the authorised firearms officers who had been involved in these fatal shootings frequently lay at the evidential centre of the inquests and interviews were conducted with both former and serving firearms officers. Most officers interviewed had been involved in more than one of these contentious inquests and together, they collectively had been involved in inquests that fell within all three periods of the research timeline. Interviews of no more than sixty minutes were conducted in a confidential setting. In order to maximise the number of officers willing to be interviewed, they were all provided with a choice of format whether by way of a face-to-face interview in the physical location of the officer's choice, or by audio or video means. Each of the firearms officer interviewed was asked the following questions:

1. What is your background as an armed police officer?
2. What (contentions) inquests have you been involved in?
3. What was the extent of that involvement?
4. For each inquest identified at Q.2 what is your opinion of

   (a) The inquest (its preparation and final hearing)

   (b) The other interested parties

   (c) The coroner

   (d) The nature of the questioning

   (e) The verdict/conclusion?

This form of questioning was intended to be semi-structured with open ended questions asked that served to guide the firearms officers through the subject areas with which

this research is concerned. This style of interview also provided each officer with the opportunity to convey their experiences and opinions of this difficult and emotive subject that might otherwise be lost in a more closed questioning format.
Further, due to the length of time that had elapsed since some these inquests had been concluded, it was unrealistic to expect these officers to be able to remember each in the greatest of detail that a more specific set of closed questions would necessarily require. In selecting interviewees it was made known by several who agreed to be interviewed, that many of their former colleagues did not wish to participate as they no longer wanted to recall or talk again about the deaths in which they had been involved and that had occurred a considerable number of years earlier.

Many of the officers who agreed to be interviewed had previously served as an active authorised firearms officer often in both a county police force as well as in a police force that served a major metropolitan area. These firearms officers had all been involved in one or more of the contentious inquests. This had been in either a primary role, an investigation officer or had acted in an advisory capacity and had personal experience of these inquests and having been required to give evidence as a witness at one or more of the contentious inquests. Most of the officers who agreed to an interview were no longer actively serving firearms officers having retired from the police service. A minority of the officers had moved into a non-active role within their police authority.

Although it had been intended to make an audio recording of all of the interviews with the firearms officers, this proved impractical due to the nature of the confidential location of the officers' choice.[377] Another difficulty audio recordings presented was the maintaining the anonymity the officers had previously been granted by the coroner and the assurance of confidentiality given for the purpose of this research. Identifying details of these officers and the inquests in which the officers had been involved became known during the course of the interviews, thereby potentially putting their

[377] Three officers opted to be interviewed together in a communal space in a Police Federation Building to which public access is restricted.

anonymity at risk.[378] Therefore, in order to maintain a uniform approach to the treatment of these interviews a less conventional approach had to be adopted.

Collectively, the firearms officers interviewed, had been involved in fourteen inquest as set out in Table 10. Neither Table 10 or the subsequent summary of the interviews in Table 11 attributes or is intended to attribute any specific inquest to any individual firearms officer that was interviewed in order to maintain the anonymity granted by the coroner and abide by the assurance of confidentiality given in this research. As it was usual for multiple firearms officers to give evidence at the same inquest, the identification of the name of the inquests in which they had collectively appeared does not compromise this anonymity or confidentiality. Consequently, Table 10 is utilised only as a means to demonstrate, the dates of the inquests in which these officers had collectively been involved and the allocation of a cipher is not intended to correspond with any cipher that may have been given to them at any of these inquests.

Table 10: The inquests - firearms officers[379]

1990 to 2000	2001 to 2012	2013 to 2018
Michael Fitzgerald	Harry Stanley	Dean Joseph
James Ashley	Colin O'Connor	
Diarmuid O'Neill	Jean Charles de Menezes	
	Azelle Rodney	
	Simon Murden	
	Terry Nicholas	
	Robert Haines	
	Mark Nunes & Andrew Markland	
	Mark Saunders	

[378] Anonymity was granted by the coroner due to the actual or perceived threats to the safety of the firearms officers and their families. At some inquests these 'threats' necessitated stringent security measures as seen at the inquests of Jean Charles de Menezes and Terry Nicholas as the final hearings were required to be held in public, where armed officers, airport style security and 'sniffer' doges were utilised. Therefore, all records of these interviews have been kept securely and will only be made known to the author's supervisor if necessary.

[379] This table sets out the different inquests the armed officers who took part in the interviews had been involved. All the officers interviewed had been involved in multiple inquests although not always as a principal officer.

In order to treat these interviews in an identical manner a written record was immediately compiled from the notes taken during each interview which provided a contemporaneous account of the officers' views of the inquest in which they had been required to participate. In the following accounts of the interviews, each officer has been referred to by a cipher to protect any anonymity that had been previously granted by the coroner and to provide confidentiality for the purposes of this research. Among the firearms officers who were interviewed, some of them had been involved in more than one fatal shooting and several different officers who participated in these interviews had been involved in the same fatal shooting and therefore had taken part in the same subsequent inquest.

8.1.1 Officer 'A'[380]

Officer 'A' was an experienced firearms officer who had worked both inside and outside a major metropolitan area and had been involved in several police shootings, which included two fatalities. The involvement of Officer 'A' had varied between that of being placed in an operational role or with an investigative responsibility in other fatal shootings. Officer 'A' had also taken part in several armed operations in which shots were fired but where no fatalities were sustained.

Officer 'A' acknowledged the importance of inquests and regarded them 'as a good thing as police officers should be accountable for their actions.' Officer 'A' viewed the inquests that had concerned a fatal police shooting as moving away from their original purpose of finding facts in answer to the question of 'how' the deceased had died and considered that these inquests were being used as a means to focus upon and question the reliability of the intelligence received by the police authority and which had informed the police operation intended to apprehend the deceased but during which they had died.

[380] Author's personal interview with Officer 'A' conducted by way of video means on 14 March 2019 from private locations.

Officer 'A' recognised that some security sensitive and confidential intelligence information could not always be disclosed to the coroner. This lack of disclosure helped create a perception of an absence of transparency on the part of the police force, with firearms officers frequently criticised by the bereaved and those acting on their behalf for this perceived unfairness. Officer 'A' also spoke about the sense of there being an apparent disconnection at a contentious inquest. This arose between those persons that had been responsible for gathering the intelligence, the decision maker that had authorised the armed operation and the firearms officer taking the operational decision to use their firearm, which resulted in the loss of life. As a result, this

perceived disconnection between the interests of these distinct groups had caused them to 'pull in different directions' at the inquest.

Officer 'A' regarded interest groups who wanted the armed officers to be treated as suspects rather than as witnesses by the independent investigatory body as 'naïve in the extreme as police officers have the same rights as members of the public.' Officer 'A' believed if the investigating body routinely treated firearms officers as suspects, police officers would be reluctant to take up or continue in that role. In any event, to treat firearms officers as suspects would be likely to lead to them relying on their legal rights and their giving a 'no comment' interview. Officer 'A' felt this lack of cooperation would hinder rather than help an investigation into the circumstances of the death and would be more likely to prevent the disclosure of facts, that might otherwise assist the bereaved. Officer 'A' also added that in some instances 'The family would never be satisfied.'

Officer 'A' also believed that there was a tension between the criminal law that made provision for the use of reasonable (fatal) force in specific circumstances and the Human Rights Act 1998, which regarded the use of fatal force as being appropriate only where it was 'absolutely necessary'. Officer 'A' recalled that preparation for the inquests in which he was required to give oral evidence had been made available by the police authority in which he had served. Officer 'A' recollected the terrible grandstanding style of advocacy adopted by one lawyer who was representing a

bereaved family at one of these inquests in which he had been involved as an investigating rather than a principal officer.

Officer 'A' also expressed the lack of confidence firearms officers had felt in the IPCC and its investigators after it had been newly formed and taken over the investigatory responsibilities from the PCA. Officer 'A' also spoke about the perception of bias created against firearms officers in the handling of information related to a shooting and how it had been released to the media by the investigating body.

8.1.2 Officer 'B'[381]

Officer 'B' had over sixteen years' experience as an authorised firearms officer and had been involved in three fatal police shootings during this time. During the interview, Officer 'B' said that he was aware that many of the other firearms officers involved in these fatal police shootings did not want to be interviewed, as 'They did not want to rake the past up and did not trust books.'

In the fatal shooting incidents in which he had been involved, Officer 'B' stated that some of the armed officers had felt as if they were on trial by the media after the fatality. Officer 'B' recalled that firearms officers were unable to speak out about the events that had happened and had felt unsupported by their police employer. Officer 'B' thought that these fatal incidents took far too long to be investigated and that the subsequent inquests took far too long to be concluded. Officer 'B' stated that during the investigation by the independent body a firearms officer may be suspended from active duty for a lengthy period and that as a consequence, an 'us' and 'them' mentality developed. Officer 'B' felt that a particular investigating body had often wanted a criminal conviction of a firearms officer in order 'To get credibility in the eyes of the public' and was also critical of the poor treatment received by some bereaved families from one public body.

Officer 'B' had found the inquests in which he had given evidence as 'variable' and described one as 'daunting'. Officer 'B' stated that nobody in the police service had

[381] Author's personal interview with Officer B conducted by way of video call on 20 November 2018 from private locations.

expected the Azelle Rodney inquiry to conclude with a verdict of 'unlawful killing' or that former firearms officer Antony Long would be charged with Azelle Rodney's murder and queried what 'new' evidence had come to light during the inquiry to justify the prosecution. Officer 'B' also stated that he felt that the delays between Azelle Rodney's shooting in 2005, the outcome of the inquiry in 2013 and then the criminal trial in 2015 had created the biggest problem, as everyone involved had been unfairly left in limbo for too long a time.

Officer 'B' acknowledged the importance of inquests but felt that they had become more adversarial, as there were more pressure groups in existence than before and each had its own agenda. Officer 'B' also stated that armed police officers viewed the aggressive cross-examination from those representing the bereaved that frequently occurred at these inquests, as intended to put officers in danger of a prosecution. Despite this treatment by legal representatives, Officer 'B' stated that he remained of the opinion that bereaved families should be legally represented at these inquests although queried whether jurors were still required.

8.1.3 Officer 'C'[382]

Officer 'C' was a currently serving officer with over 20 years' experience, who had been involved in two fatal police shootings although had only been required to give evidence at the inquest of one of them.

Officer 'C' considered that the manner in which the independent body had carried out its investigations could be quite an aggressive experience for some officers, although he recalled that his own experience had been positive and the investigation to be 'fair' as after the twenty-eight day review period had ended, he had been allowed to return to active duty. Officer 'C' considered that press reporting of these fatal police shootings contained a general tone of suspicion and lacked impartiality. Officer 'C' recalled that in preparation for the inquest in which he had been required to give oral

[382] Author's personal interview with Officer C conducted by way of video call on 15 November 2018 from private locations.

evidence, he had been allowed to re-read the statements he had given previously and was taken through his evidence beforehand before giving his oral evidence at the inquest. However, he had found the legal representative for the family to be aggressive in cross-examination and was of the view that in general, families believed officers were 'covering things up' in the evidence that they gave at the inquest.

Officer 'C' also commented upon the basic lack of understanding the chairman of the Azelle Rodney inquiry had demonstrated as to how authorised firearms officers operated. Officer 'C' felt that inquests should continue to be held for these contentious deaths but thought that the jury might benefit from being provided with an overview

as to the work of authorised firearms officers at the beginning of the inquest. Officer 'C' concluded the interview by saying that inquests had 'stood the test of time and would not really change anything about the inquest system'.

8.1.4 Officer 'D'[383]

Officer 'D' had been an authorised firearms officer for more than fifteen years and had served both in a police authority within a metropolitan area as well as in a county force. Officer 'D' had been involved directly in two fatal police shootings and had been indirectly involved in two other fatal incidents. Officer 'D' said that his experience of the investigating body had been variable as in one, the investigators had turned up immediately after the fatal shooting and had established an amicable relationship with the firearms officers. Officer 'D' stated that he felt he had been treated fairly on this occasion. Officer 'D' said that although, he had not been interviewed by the investigators, he had been required to make an initial statement immediately after the fatal shooting and this had been followed by the writing of a further two statements. Officer 'D' compared this experience to the one he had after a second fatal shooting where the independent investigators had been aggressive and had shown little understanding of the role of the firearms officers.

[383] Author's interview with Officer D conducted by way of video call on 16 November 2018 from private locations.

Officer 'D' recalled that at the first inquest in which he been required to give evidence, the physical setting of the coroner's court had come as 'a bit of a shock'. Although granted anonymity by the coroner and permitted to give his evidence from behind a screen, Officer 'D' was able to be seen by the coroner, the jury and the bereaved who would stare and glare at him throughout his evidence. Officer 'D' stated that 'He had found the final hearing to be quite nerve wracking' and the inquest to be a highly pressurised experience, as the questioning by the legal representative for the bereaved family was abrupt in manner and at times quite adversarial, with the officer before him having become tearful in the witness box. Officer 'D' felt that this inquest had been one-sided as the family was never questioned on why the deceased had been left in possession of a weapon or if they had been aware of his poor mental health.

During his experience of another inquest, officers had been accused of conferring with each other and concocting their evidence. Officer 'D' also remarked that if there was a lack of anonymity for firearms officers at an inquest, that this would make him nervous and afraid for his safety. Consequently, this uncertainty about anonymity at an inquest was making it difficult for him and colleagues to carry out their roles.

8.1.5 Officer 'E'[457]

An authorised firearms officer for over ten years both in a county force and in a metropolitan area, Officer 'E' had been involved in two fatal police shootings and had been required to give evidence in both inquests. The completion of the Investigation report had taken a long time and once a date for the inquest was announced he had been prepared for the inquest as if it were an adversarial forum. Officer 'E' said he had been meticulously briefed for the inquest by his police force on what to expect and that 'A picture was painted in no uncertain terms that there would aggressive questioning from the family.' Preparation for the inquest also took the form of 'role play' and familiarisation with the statements that he had previously made, with background information provided on the legal representatives who would be representing the interested parties.

At the first of the inquests in which he had been involved, Officer 'E' found the legal representative for the bereaved family to be prone to play-acting. This behaviour had been combined with the inappropriate use of facial expressions while police witnesses gave their evidence and the adoption of a style of questioning that was on occasion, met by muttered comments from members of the jury. Officer 'E' also criticised the layout of the court, as he found the physical closeness of the legal representatives to the witnesses to be unacceptable. Officer 'E' stated that he felt that there was pressure on certain witnesses to paint a glowing picture of the deceased. However, it had been made clear to him in one inquest, that not all family members felt the same way as he recalled that a family member at one inquest had wanted to thank the firearms officers for their role in the death of the deceased.

[457] Personal interview with Officer E conducted by telephone on 12 November 2018 from private locations.

The second inquest in which he had given evidence had followed a similar route to that of the first as to the manner of his preparation for the inquest by his police authority employer. Again, the investigators had 'dragged their heels in conducting the investigation' and had prevented officers from returning to active duty for more than twelve months. Officer 'E' felt that the investigation carried out was biased and lacked independence as it had very much been led by the personality of the chief investigator, who he felt was trying harder to appease the bereaved family than to find facts. Officer 'E' stated that he regarded the lead investigator as having been 'inept' and responsible for the delays in concluding the investigation.

Officer 'E' found the legal representatives for the bereaved family to have adopted at the inquest, an attitude that could be described as 'grandstanding' and who would cut his answers short before they had been fully given. Officer 'E' found this questioning to be highly aggressive and the inquest adversarial. Although he had been prepared

for this in his role plays, he had expected it would be more sympathetic in tone than it was. Officer 'E' recognised that due process was required after a fatal police shooting and accepted that a police officer was expected to answer questions about the part they had in the death.

8.1.6 Officer 'F'[384]

Officer 'F' had been a firearms officer for over fifteen years and been involved in two fatal police shootings before he had retired from the police service. One of the inquests in which he had been involved, although not as a key witness had included an investigation of the type of ammunition used by the armed officers. Officer 'F' stated that he had not received any preparation for this inquest by his police service employer and had not been able to review his statements before giving his oral evidence and unlike other police forces, which provided study time and other resources to prepare

its officers that were giving evidence at inquests, none of these facilities had been made available to him.

Officer 'F' felt that the inquests in which he had been involved, had failed to investigate how the deceased had been able to acquire and use a firearm or other weapon against police officers. Consequently, the jury had not been permitted to consider the role of the bereaved family in allowing the deceased to obtain and keep such a weapon. Officer 'F' also felt that there had been an inconsistency in the way the independent investigations had been carried out and although now retired, expressed a wish never to have to give evidence at an inquest again.

8.1.7 Officer 'G'[385]

Officer 'G' had been a firearms officer for over fifteen years and had been involved in several fatal police shootings in varying capacities as a serving officer in major metropolitan police authorities as well as in county police forces. During his involvement in the subsequent investigations, Officer 'G' had found the inquest

[384] Authors face to face interview with Officer F conducted on 19 November 2018 in the Police Federation Building (Surrey) by invitation.
[385] Author's face to face interview with Officer G conducted on 19 November 218 at Police Federation Building (Surrey) by invitation.

process to be overly long and drawn out and because of this delay, it had tended to lose focus on its role of finding facts and instead, the inquest became more about a question of 'Who is to blame?'

Officer 'G' stated that he found the independent investigators had demonstrated a lack of knowledge about how authorised firearms officers work and referred to an incident where the issue of how many shots had been fired by firearms officers had become one of the central issues in the subsequent investigation. Officer 'G' also criticised the length of time the CPS took in its decision making about whether or not to bring criminal charges against the firearms officer. Officer 'G' was of the view that where the police operation had been spontaneous rather than planned, the ambit of the inquest had become too wide. In one particularly high profile inquest, Officer 'G' said that 'He had found the behaviour of the legal representatives for the family to be overly aggressive and had treated the inquest as if it were a 'game.' He also regarded the

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behaviour demonstrated by one of these legal representatives as both 'Immature and disgraceful.'

Officer 'G' found that it had become more difficult for firearms officers to retain their anonymity at the inquests, particularly with the use of social media becoming more widespread, as after one fatal shooting the family of the deceased had run a media campaign against police officers. Officer 'G' thought that inquests had become much more adversarial in nature as the bereaved and their representatives sought to gain access to the armed officers training manuals and policy documents in order to put them into evidence at the inquest. Officer 'G' felt that the legal representatives for the bereaved family put the firearms officers much more on the defensive than was necessary when giving their evidence at the inquest.

Officer 'G' accepted the need to hold inquests as the bereaved family 'had a right to know what had happened to their family member' although considered that the inquest no longer provided a sufficiently efficient process in which to investigate how the deceased had died. Officer 'G' also acknowledged the family's right to seek a review

of the CPS decision not to bring any criminal prosecution but commented that this had added to the delays in holding the final hearing of the inquest. Officer 'G' thought that these delays not only had an adverse effect on the family members, but also on the firearms officers, many of whom had required support through the investigation and inquest process and who, like the bereaved family also wanted closure.

8.1.8 Officer 'H'[386]

Officer 'H' was an experienced police officer who had specialised in providing support to authorised firearms officers after a fatal shooting. Officer 'H' was of the view that many of these contentious inquests had been treated as a 'game' by a number of legal representatives who regularly represented the interests of bereaved families. Officer 'H' was also of the opinion that these lawyers would use 'Coercive strategies to try to trick and trap officers when giving their evidence at the inquest.' Officer 'H' also questioned whether the motivation of these legal representatives was more about

raising their own profile and generating business for themselves, than it was about putting the bereaved family's interests first. Officer 'H' thought that as a result of the nature of these inquests the families were forgotten as was the human cost of them, particularly in the inquests where the jury had given verdicts of 'suicide by cop.'

Officer 'H' was also of the view, that in order for firearms officers to ensure that legal representation for the investigation and inquest was made available to them by their police authority employer, officers had been expected to repeat in evidence the content of their previous statements. The writing of this kind of statement had been helped by the training provided.

Officer 'H' commented that it was recognised by firearms officers that although inquests were meant to be non-adversarial it was difficult to avoid an adversarial approach arising, particularly where the deceased had been in legal custody. Officer 'H' thought that the poor quality of the third party investigation and the delay caused by these to the inquest had consistently been a matter of concern for armed officers.

[386] Author's face to face interview with Officer H conducted on 19 November 2018 at Police Federation Building (Surrey) by invitation.

Officer 'H' stated that he had received complaints from firearms officers, who had said that they had wanted to be treated fairly but that the investigators had made them feel like suspects in the investigation rather than as witnesses.

8.2 Analysis of common themes

It is acknowledged that a common method of qualitative analysis in a thesis is by using codification tools and techniques such as those of NVivo. However, these interviews did not easily lend themselves to this form of analysis. This is attributable to the difficulties with making audio recordings in the settings chosen for the interview by a number of the firearms officers, the relatively small number of interviews that were able to be conducted and the complications presented by the importance of preserving anonymity as well as the assurances of confidentiality. Therefore, in order to maintain a uniformity of approach a method of analysis of the interview material was adopted which provides a unique insight into the views of those who are at the centre of the events that have led to a police-shooting death and from which, several common themes emerged from the interviews which have been summarised in Table 11.

Table 11: Predominant themes - firearms officers

Officer	Witness or suspect	Accountability	Delays	Adversarialism	Reform
'A'	X	X	X	X	X
'B'	X	X	X	X	X
'C'	X	X	O	X	X
'D'	X	O	O	X	O
'E'	X	X	X	X	X
'F'	O	O	X	X	O
'G'	X	X	O	X	X
'H'	X	O	O	X	O

Key:

X = issued addressed
O = did not comment

8.2.1 Witness or suspect

Most firearms officers expressed strongly held views that they should be treated as witnesses and not as suspects by the investigating body responsible for conducting an investigation into the fatal shooting and reported as having different experiences depending on the identity of the investigators. The officers were of the opinion that to do otherwise, would likely lead to less information being provided to the family about the circumstances of the fatal shooting, if officers sought to rely on their legal rights as any other suspect or potential defendant.

8.2.2 Accountability

None of the officers interviewed sought to assert that firearms officers should not be required as witnesses, to give a full account of their actions either to the independent body investigating the fatal shooting or at the inquest. While accepting the need to be accountable for their actions in the forum of the inquest, officers did not accept that the misreporting of the fatal shooting and consequent misperception caused by the media was conducive to their fair treatment.

8.2.3 Delays

Delays in completing the investigation was also a common area of concern among many of the firearms officers as this had adversely affected them in their professional roles and their ability to continue in an active role as a firearms officer. The officers recognised that these lengthy delays and their impact on the inquest, may have also caused . Many of the firearms officers expressed frustration at the delays to the inquest being concluded and the additional stress and anxiety to the bereaved family as well as to their own personal and professional lives.

8.2.4 Adversarialism

Adversarialism was one theme on which all the firearms officers commented. The firearms officers were broadly in agreement that inquests had become more adversarial and attributed this to the behaviour of the legal representative acting on behalf of the bereaved. Several of the firearms officers viewed the participation of the lawyers that

represented bereaved families in uncomplimentary terms. The officers felt that these inquests had become less about being able to provide their evidence to the inquest as to how the deceased had died and more to do with these legal representatives seeking to bolster their own profile by adopting an unnecessarily aggressive style of questioning and of grandstanding during the inquest. It was because of this expected adversarial approach, that many officers had been provided with significant opportunities to prepare for these inquests by their police employer as if they were giving evidence in a trial

8.2.5 Reform

Many officers agreed that inquests should continue as the forum in which they gave their account of what had occurred to the bereaved that led to the loss of their family member. Most of the firearms officers interviewed felt that inquests were still necessary but felt that changes were needed as they had become overly broad in their ambit and adversarial at the final hearing. This matter was damaging to the interests of the bereaved families rather than as a positive means by which the inquest provided the answers and explanations they rightly sought.

8.3 The lawyers

Over the timeline with which this research is concerned, an informal cadre of lawyers has formed made up of solicitors firms and the barristers they instruct and who have acquired experience and expertise in providing representation at these police-shooting inquests. Although a large number of lawyers were approached for an interview and who had regularly represented the differing interests the various interested parties and persons at these inquest, there was demonstrated a considerable reluctance to participate, usually in the form of a lack of any response to the Although, only a small number of lawyers agreed to be interviewed for this research, they had collectively provided legal representation for interested parties and persons in twenty-six of these police-shooting deaths held in all three periods of the timeline with which this research is concerned.

Table 12: Number of inquests - lawyers [387]

Inquests 1990 to 2000	Inquests 2001 to 2012	Inquests 2013 to 2018
2 inquests	17 inquests	5 inquests

As with the firearms officers, the lawyers who were interviewed had appeared at many of the same inquests, albeit representing the interests of different interested parties or persons. Similarly, the lawyers requested that their identity confidential as they all continued to represent interested persons in inquests into state-related deaths.

Therefore, to accommodate this expressed preference and to maintain a uniform approach the use of a cipher was again adopted for each lawyer. However, a further complicating feature arose from the fact that the identity of any lawyer representing an interested party or person was frequently ascertainable from media and other public sources, as unlike the firearms officers, only one or occasionally two lawyers, appeared on behalf of each interested party or person. Therefore, to avoid inadvertently breaching confidentiality, the views of these lawyers have been reported in more

general terms to avoid inadvertently linking the representation they had provided, to any particular inquest. In order to retain uniformity in the method of analysis employed in this research, the case studies were compiled from the contemporaneous notes made in the telephone and face-to-face interviews as well as the written answers provided.

The lawyers were asked to answer a defined list of questions as well as being provided with an opportunity to add any other comments they felt were relevant to the purpose of this research. The questions asked were as follows:

1. Have you participated at any inquests in the following periods where the deceased has died as a result of a shooting by armed police officers?

[387] These figures relate to inquests only and not to any inquests that were converted to public inquiries.

(a) 1990 to 2000

(b) 2001 to 2012

(c) 2013 to 2018

2. Which inquest, when and what police force?
3. What was the coroner's jurisdiction for each inquest identified?
4. Which person(s) did you represent?
5. Did you attend any pre-inquest review hearings?
6. If yes, how many?
7. If no, what was the reason?
8. What was decided at the pre-inquest review hearings?
9. Were preparations for the final inquest hearing adequate?
10. If not, why not?
11. Did your client give evidence at the inquest?
12. What was the verdict/conclusion at the inquest?
13. Did you think this verdict/conclusion was appropriate?
14. What are your thoughts in the way the/these inquests was/were (i) prepared for and (ii) conducted.
15. An inquest is an inquisitorial fact-finding investigation of the circumstances leading up to the death, it is not intended to be adversarial. Does this statement accord with your direct or indirect experience?
16. Please explain your answer to question number 15.
17. Were you satisfied with the outcome of the inquest?
18. Please explain your answer to question 17.
19. Is there anything you would change about the way inquests into contentious deaths are conducted? If 'yes', what?
20. Any other relevant comments.

8.3.1 Lawyer 'A'[388]

Lawyer 'A' had extensive experience of these contentious inquests having provided legal representation at them since the 1990's. Lawyer 'A' recalled that in the first

[388] Face to face interview between author and Lawyer A on 10 April 2018 at interviewee's professional location.

police-shooting inquest experienced, the bereaved family had wanted the coroner to leave a verdict of 'unlawful killing' to the jury and representations had been made to this effect. However, the coroner had decided that this should not be left to the jury to consider.

In another contentious inquest held during the 1990's Lawyer 'A' recalled that there had been no preliminary hearings held and that disclosure of the evidence had not been provided to the interested parties before the start of the final hearing. A written application to the coroner had been made seeking the grant of anonymity had been made by the firearms officers and the final hearing had been 'rushed through' and concluded within a matter of days.

Lawyer 'A' recalled that during the 2000's the holding of preliminary hearings became more commonly held by the coroner and that the disclosure of evidence to the interested parties was made more frequently than had occurred previously. As a consequence of these two measures, Lawyer 'A' stated that all interested parties had been provided with a proper opportunity to prepare for the final hearing.

Lawyer 'A' did not consider that a further change to the legislation or the coronial service was necessary in light of the new 2009 Act but considered that a change to the mindset and approach of coroners to these contentious inquests was required in order to achieve more consistency of approach between them. Lawyer 'A' also suggested that |coroners should adopt a more searching and investigative approach and should be prepared to look critically at the official reports, although accepted that coroners 'Do not have the funding or the time to really crunch the papers'.

Lawyer 'A' stated that there had been some great coroners (past and present) who had been prepared to get to the bottom of the reasons why the death had occurred and who had demonstrated that they had the right mindset for these contentious inquests. Lawyer 'A' also suggested that coroners should prevent the repetitious questioning of witnesses by legal representatives for the interested parties, although questioning of witnesses 'from a different angle' should be permitted. Lawyer 'A' did not regard

these contentious inquests as having become overtly adversarial and did not suggest that any further changes should be made to them.

8.3.2 Lawyer 'B'[389]

Lawyer B had over fifteen years' experience of these contentious inquests. Lawyer 'B' stated that in some of these inquests the firearms officers had been provided with separate legal representation as they had perceived their interests to be distinct from those of the police force in which they served. In Lawyer 'B's experience, pre-inquest review hearings had been held regularly by the coroner and even before the CJA had come into effect and the Chief Coroner's Guidelines had been introduced. Lawyer 'B' had found the coroner's preparation for these inquests to be adequate, particularly considering the budgetary constraints and inadequate facilities in which, they frequently had to perform their role and that, in general the coroners had conducted the inquests 'in a fair and thorough manner.'

Lawyer 'B' thought that the inquisitorial role of these contentious inquests had disappeared and that the inquest:

> Was seen by the deceased's family in many instances as an attempt to undermine or reverse the decision of the CPS, where there has been a decision not to prosecute the officer who fired the fatal shot….. It is seen by the bereaved as an opportunity to uncover the 'injustice' done to their family and to obtain an 'unlawful killing' conclusion at almost any cost.

Lawyer 'B' had experienced significant delays in the holding of numerous final inquest hearings, many of which had been held many years after the death had occurred. Lawyer 'B' thought that these delays had frequently been caused by the time taken by the IPCC to conclude its report and the CPS to make its decision on a prosecution. Further delays were often contributed to by a bereaved family's request for a review of the CPS decision and which on occasion had been followed by an application for judicial review, where the decision not to prosecute had remained unchanged. Lawyer

[389] Written responses provided by Lawyer B on 10 February 2020.

'B' thought that all of these matters had served to entrench views and create intransigence between the interested parties and persons. This stance had the result that by the time of the final hearing, feelings displayed by bereaved family members and a significant group of their vocal supporters and sometimes their lawyers often included a deeply held animosity towards the police force and its firearms officers.

Lawyer 'B' was also of the opinion that at the inquest hearing that firearms officers have often had to withstand very significant attacks on their character with suggestions put to them in cross-examination that they were 'liars'. Lawyer 'B' was also of the view that this accusation was usually made without any evidence to support it and often on the basis that families wished the facts to be other than the way police officers recalled them to be. Consequently, Lawyer 'B' believed the inquest process:

> Is anything but an attempt to inquire into what actually happened, it is largely a trial….. and had resulted in raising the temperature between the police and the bereaved, rather than doing anything to mend or repair the antagonism or public disquiet that had arisen.

It was Lawyer B's view that these contentious inquests sometimes also created friction between individual armed officers and the police authority by whom they were employed. In the opinion of Lawyer 'B' opinion, the police force employer had often sought to strike a balance between its interests and those of its firearms officer. Consequently, a police authority had on occasion wanted to distance itself from the responsibility of the actions of its officer in case the jury returned an adverse verdict or conclusion, while at the same time appearing to be supportive of them as the police force depended upon its firearms officers to carry out the most difficult and dangerous tasks. As a consequence of the intense scrutiny endured by these officers, particularly by the principal firearms officers over a prolonged period Lawyer 'B' was of the view, that it had been no coincidence, that it had resulted in fewer officers willing to volunteer to become firearms officers.

> When the police authority seeks to sit on the fence, rather than unequivocally supporting its officers, this resulted in the community distrusting the police and the armed officers distrusting the organisation for whom it worked, thereby leading to a very unwelcome result for the public and public safety.

Lawyer 'B' was of the opinion that these inquests need to be dealt with much more quickly and suggested that this could be done by the IOPC reporting on the issue of the actual shooting within weeks or months of the death. Thereafter, if a report on every aspect of the armed operation was required, this could be dealt with in a supplementary report. Lawyer ‘B’ stated that as the IPCC investigators had not usually been lawyers, legally trained or otherwise experienced in investigation techniques, this has led to poorly reasoned thinking in assessing the culpability or otherwise of the principal armed officers in the reports. The effect of this had been that bereaved families had developed an unrealistic expectation of what outcome to expect at the inquest. From the officer’s perspective, the IPCC and IOPC appeared to have been on ‘the side of the family’ and exemplified this by its investigators going to local meetings after these fatal shootings and making comments on the incident prior to any investigation.

Lawyer ‘B’ was of the view that when families had developed unrealistic expectations of the potential outcome to the investigation, this has led to greater antagonism in the whole investigative process and essentially it had become a cycle of conflict. Lawyer ‘B’ was of the view, that the notion that at an inquest there are no parties and no sides at an inquest as it is merely a search for the truth ‘is a myth’. As a consequence, noone trusted the process of investigation into the death. It was not suggested that a full investigation into what had occurred was not welcome, although the time taken and the approach to concluding these inquests was inexplicable.

Lawyer 'B' suggested that an alternative to the current inquest system would be to hold a judge led hearing without a jury that determined the issue of the actual shooting only. The judge could decide whether witnesses were required and if so, whether they needed to be questioned. There would be a legal representative for the family, the firearms officer and if necessary, the police organisation. The hearing dealing with just the act of the shooting would be relatively short since the only issue for the judge to determine would be what was in the mind of the officer at the point of discharging their weapon as the fact of the death that it caused is never in dispute. Lawyer 'B' was of the view that as the question of whether the officer acted in self-defence is the one that needs to be answered, the evidence in that regard could be dealt with, within days.

Once that issue has been dealt with, any later jury inquest could decide all of the other issues the coroner agrees to include in the scope of the hearing. The judge dealing with the shooting would write a report and be answerable to Parliament. Lawyer 'B' also suggested that the judge could also recommend criminal or disciplinary proceedings against the principal officer(s) if it was appropriate to do so.

8.3.3 Lawyer 'C'[390]

Lawyer 'C' also had more than fifteen years of experience of multiple contentious inquests and had shown that the firearms officers involved in these fatal shootings felt the pressure of an inquest as if it were a trial. It was the experience of Lawyer 'C' that pre-inquest review hearings had been held by coroners long before the Chief Coroner's guidelines were introduced, as these inquests had frequently presented complex issues. The preliminary hearings held had routinely concerned issues that included the determination of the ambit of the inquest; the identity of the interested parties or persons; the disclosure of evidence, the seating position of the interested parties and persons as well as the reporting provisions for the final hearing and the preparation and the provision of copies of the documentary bundles of evidence for the interested parties and for the coroner.

Lawyer 'C' experience of these contentious inquests had seen the firearms officers represented separately from their police force employer and had, where required, given oral evidence at the inquest. However, Lawyer 'C' thought that 'we have crossed the line into the adversarial inquest' and referred to the inquests of Harry Stanley, Jean Charles de Menezes and Mark Saunders' as examples of this adversarialism. It was the view of Lawyer 'C' that the final hearing of the inquest had often been conducted by those representing the bereaved as if it was a preparation for a civil claim for damages, which manifested in their manner of questioning and conduct of the cross-examination of the firearms officers. Lawyer 'C' was of the view that some coroners were able to deal with this adversarial approach although other coroners had been less able to do so. Lawyer 'C' stated that there were local variations in the approaches of coroners. While some coroners are sufficiently robust and able to deal with the extra issues and

[390] Interview held by author with Lawyer C and conducted by telephone on 24 January 2020 from private locations.

stresses these inquests brought, other coroners would allow the family's legal representatives an excessive amount of leeway at the final hearing to the detriment of the inquest process.

Lawyer 'C' was also of the view that the approach taken by the IPCC and IOPC often put armed officers into a hybrid role that fell between treating them as a suspect on the one hand and as a witness on the other, as they were under an Article 2 duty to investigate whether the fatal force used was or was not justified. Lawyer 'C' was also of the opinion that a firearms officer's status could change 'In the blink of an eye from that of witness to suspect' and was aware that firearms officers were routinely advised to exercise caution when giving their initial statements, although all officers had ultimately provided a detailed written statement as required by the post incident procedures adopted by their police authority.

Lawyer 'C' reiterated his view that 'Inquests had become adversarial and the crossexamination conducted by some legal representatives, as if it were a murder trial rather than an inquest.' It was also the view of Lawyer 'C' that the ambit of these inquests had been excessively extended so as to allow legal representatives for the bereaved to 'have a go' at the planners of the armed operation as well as the officers themselves. Lawyer 'C' did not consider that the adversarial approach taken to these inquests by some of the representatives of the bereaved families had helped achieve the purpose of the inquest. Lawyer 'C' also believed that family members had often been given unrealistic expectations by their representatives as to what the inquest could achieve, particularly where they had been led to believe that there had been a 'police cover-up'.

Lawyer 'C' thought that more funding for these inquests was required to ensure that they could be dealt with more expeditiously and recognised that even where the report of the IPCC and the IOPC had been concluded, the final hearing still took too long to be held. However, Lawyer 'C' was of the view that the inquest jury system should be retained and thought that it worked more successfully than public inquiries into police shootings. Therefore, Lawyer 'C' thought that these contentious inquests should remain in the inquest forum rather than routinely becoming the subject of a public inquiry. Lastly, Lawyer 'C' criticised the physical facilities in which these inquests

had often been heard and commented that some venues did not easily allow for the maintenance of the anonymity granted to witnesses by the coroner due to the lack of facilities and rooms provided at any particular location to the interested persons and parties.[391]

8.4 Common themes among the lawyers

In their interviews the lawyers expressed similar concerns as to how these contentious inquests had developed and these are summarised in Table 12.

Table 13: Predominant themes - lawyers

Lawyer	Delays	Coroners	Adversarialism	Reform
'A'	O	X	X	X
'B'	X	X	X	X
'C'	X	X	X	X

Key:

X = issued addressed
O = did not comment

8.4.1 Delays

Two of the lawyers interviewed acknowledged that the lengthy delays that had occurred in concluding these inquests were unacceptable. These delays were attributed to the entirety of the slowness of the investigative process conducted by the IPCC and IOPC, the delays in making decisions on prosecutions, as well as the lack of funding provided to the coroner to expedite these resource and time intensive inquests.

[391] The inquests have regularly been heard outside of the Coroner's Court building due to the lack of space and the amount of time they require, thereby preventing the holding of other more routine inquests. Consequently, venues, such as a Town Hall (Terry Nicholas) and the Oval Cricket Ground (Jean Charles de Menezes) have been used. A number of venues have also been chosen because of security concerns and have required the use of airport style security measures, sniffer dogs and armed officers in answer to possible threats to safety.

8.4.2 Coroners

For one lawyer, criticisms of the inquest process focused on the inability of the coroner to fully analyse the investigative report and conduct searching questioning of the witnesses, rather than an inability to fully participate in the inquest process since the use of preliminary hearings and the provision of the disclosure of evidence. This view of the coroner was not shared by other lawyers who were of the view that a fair hearing had been conducted by the coroner in these contentious inquests within the budgetary and resource constraints that were imposed upon them.

8.4.3 Adversarialism

Another theme that emerged from these interviews was the growth in the adversarial nature of these contentious inquests. Although one lawyer had expressed the view that the contentious inquests had not become overtly adversarial, the other lawyers interviewed strongly disagreed with this view. This was attributed to the blatant adversarial approach adopted by the bereaved and their lawyers in their determined pursuit of the 'unlawful killing' verdict or conclusion. This adversarialism was regarded as being a detriment to the interests of the bereaved family and to the firearms officers and compromised the efficacy of the inquest forum in these circumstances.

8.4.4 Reform

The views on the future of the contentious inquest differed among the lawyers. These ranged from there being no change required to the current form of jury inquest to the suggestion of a two stage approach to the contentious inquests. The adoption of such an approach would provide a solution to the long and unacceptable delays, that would benefit all of the interested parties, including the bereaved. By determining the central issue of the lawfulness or otherwise of the fatal shooting as an early first stage, this would provide certainty to the bereaved and the armed officers alike on the issue of accountability, before a more lengthy second stage that dealt with issues of policy and planning could be held.

8.5 Conclusions

A primary concern for many of the firearms officers was the treatment that they had received from the investigatory body and at the inquest. For these officers, the concept

of ‘fairness’ was interpreted to mean a right to be treated as a witness and not as a suspect in the investigatory process, being permitted to resume active duties without undue delay and, if necessary allowed to rely on the same rights afforded to any other suspect in a criminal process. Although the firearms officers’ experiences of inquests had been varied, several officers had been led to expect an adversarial hearing and had consequently prepared for the inquest as if it were a trial. Despite the officers’ misgivings about their treatment by the investigators and their unpleasant experiences of the inquest, none of the firearms officers suggested that they should not be required to give an account of their role in the death of another in the course of carrying out their duties.

The firearms officers’ view that an adversarial ‘trial-like’ approach had predominated in many of these contentious inquests was supported by the views of two highly experienced lawyers. These lawyers had provided representation in a significant number of these inquests concluded during the identified timeline. These lawyers attributed the encroachment of an adversarial approach to the bereaved and their legal representatives in their pursuit of ‘accountability’ by firearms officers and a finding that their family member had been unlawfully killed by the state and its agents. This damaged the inquisitorial purpose of the inquest to the detriment of both the bereaved and the firearms officers.

In the next chapter, the views of the bereaved are considered together with those of groups that specialise in campaigning in support of their interests to ascertain whether they share similar views on the growth of adversarialism in these contentious inquests or if they diverge from them. Consideration was given as to whether it was possible and useful to conduct interviews with other participants in these inquests such as jury members. However, due the confidential nature of the name and addresses of jury members, which in any event was accessible only from the original inquest file material, this was not considered to be a viable group of potential interviewees.

CHAPTER NINE: THE BEREAVED, INTEREST GROUPS AND CORONERS

9.0 Introduction

This chapter focuses upon the views of the bereaved and the interest groups that support them. Unlike the multiple contentious inquests attended by firearms officers and lawyers, the experience of a contentious inquest by a bereaved family has been confined to the inquest concerning the death of their family member.[466] Although the first-hand views of bereaved family members were sought through the intermediary of interest groups with whom they had contact, interviews could not be held due to a multiplicity of factors. These factors included the traumatic nature of the subject matter, the lengthy period that had passed since the death of a family member, the ongoing litigation or the possibility of potential litigation and the unwillingness of family members to participate in any further research that concerned the death of their family member.[467]

Consequently, for this chapter it was necessary to return to the original inquest file materials that were previously used for the case studies detailed in the previous chapters. Other sources of material that provide insight into the how the bereaved viewed the inquest of their family member include official reporting of several of the inquests held during this period, local and national media reports of the shooting and inquest, briefings and statements published by interest groups and by the family campaigns formed in response to the fatal shooting of their family member and public meetings that have been held by them.[468]

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[466] See Table 1.

[467] 4WardEverUK has adopted the position from 2017 that we would no longer refer requests of this type to family members that we have contact with. For the most part, this is at the request of many affected families.' Email exchange with author on 18 June 2019.

In 2017, 4WardEver UK and the United Families and Friends Campaign (UFFC) put their support behind new research that considers deaths after police contact in England of people experiencing mental health issues examining custody deaths from the viewpoint of the families that are affected. David Baker, ''These people are vulnerable, they aren't criminals: mental health, the use of force and deaths after police contact in England' (2019) 93 (1) Police Journal: Theory Practice and Principles 65. [468] Public meeting of the Mark Duggan family campaign 'Mark Duggan – The Truth the Whole Truth &

Nothing But the Truth'. A public meeting by the family campaign seeking 'Justice for Mark Duggan' was held on 30 November 2020 in Tottenham Town Hall which the author attended in person.

9.1 The bereaved

The automatic recognition by the coroner of an immediate family member's status as an interested party or person in these contentious inquests may have been their first contact with the coronial service.[392] In the absence of any hoped for criminal prosecution of the officer who fired the fatal shot that killed their family member, the bereaved have turned to the inquest as the only remaining process in which, it is hoped to achieve a degree of 'justice' and 'accountability' and public recognition of their loss through a verdict or conclusion of 'unlawful killing.' For many bereaved families an inquest that concludes with such a determination is seen as a step towards a positive review by the CPS of its decision not to prosecute, a subsequent prosecution of a firearms officer on a charge of 'murder' or 'manslaughter' and a conviction. However, the unfamiliar processes of this inquisitorial forum can contribute to a misunderstanding as to the purpose of an inquest, its limitations and what can be achieved from it, thereby giving rise to unfulfilled expectations on the part of the bereaved.

At the outset of this research it had been intended to conduct interviews with the bereaved who had experienced the death of a family member as a result of a police shooting. Due to the sensitivity of the subject matter and the potential for causing further distress, approaches were made to two leading organisations known to have had close contact with a number of these families.[393][394] These approaches were met with a referral to their published Family Listening Days materials and the other responded indicated that family members had expressly asked not to be contacted for the purpose of any further research as they questioned the value of it to them.[471] Therefore, other sources had to be utilised which included previously published information as well as materials contained in the original inquest files to which access had been permitted.

[392] Coroners Rules 1984 r 20(2) 1988, Coroners and Justice Act 2009 s 47.
[393] Two of the leading interest groups that provide support for families bereaved in state-related deaths are INQUEST and 4WardEver.
[394] WardEver, email exchange with author dated 18 June 2019.

9.2 The inquest files

The original inquest file materials detailed in the case studies in previous chapters have been explored regarding the extent of the bereaved's participation in the contentious inquest during each of the three periods of the timeline of this research. The file materials also revealed details about the particular concerns of family member as to the circumstances in which their family member had died. Therefore, in the absence of interviews with family members, these original file materials have again been referred to and the concerns of the bereaved family and the desired outcome is summarised in Table 13.

The file materials showed that family members raised concerns that focused on the mental health of the deceased and whether it had been necessary to use fatal force if other alternatives appeared to be available in the apprehension of the deceased. The families' belief that their family member had been unlawfully killed by the state, was reflected in the submissions made to the coroner, that the jury should be permitted to consider a verdict of 'unlawful killing' alongside any other alternatives that were appropriate to leave for the jury's consideration. The concerns raised by the bereaved in the case studies of the previous chapters and the verdict wanted by family members are summarised in Table 14.

Table 14: The bereaved – concerns and outcome sought from inquest

No.	Name of deceased	Inquest	Family concerns	Inquest outcome wanted by bereaved
1.	Michael Alexander[395]	1991	Whether the police employed a 'shoot to kill' or 'shoot to stop' police policy?	Unlawful killing

[395] Original inquest file of Michael Alexander accessed on 06/12/2018. [473]
Original inquest file of Ian Gordon accessed on 30/07/2018.

No.	Name of deceased	Inquest	Family concerns	Inquest outcome wanted by bereaved
2.	Ian Gordon[473]	1992	Concerns over Mr Gordon’s poor mental health led family to say that police had put themselves in ‘harm's way.’	Unlawful killing
3.	Derek Wallbanks [396]	1992	Although initially accepting of the police actions, the family later blamed the police for Mr Wallbanks’ death as they believed he should not have been shot and could have been ‘talked down’ as had occurred in an earlier similar incident.	Not recorded on available inquest file materials.
4.	Barry Clutterham [397]	1992	Concerns over Mr Clutterham’s mental health as he had a history of depression.	Unlawful killing.
5.	David Howell [398]	1997	Concerns over Mr. Howell’s state of mental health and treatment arose as the family thought that this had been a ‘needless killing.’	Not recorded in available inquest file materials.
6.	James Brady [399]	1998	Whether the police should have intercepted James Brady before his break-in at the social club where he was fatally shot?	Unlawful killing
7.	Michael Fitzgerald[400]	1998	Why there was an absence of trained negotiator called to the scene of shooting?	Unlawful killing and breach of ‘right to life’

[396] Original inquest file of Derek Wallbanks accessed 12/04/2019.
[397] Original inquest file of Barry Clutterham of 07/12/2018.
[398] Original inquest file of David Howell accessed 22/05/2017.
[399] Original inquest file of James Brady accessed on 12/04/2019.
[400] Original inquest file of Michael Fitzgerald accessed on 06/07/2018. [479] Original inquest file of Andrew Kernan accessed on10/05/2017.

8.	Andrew Kernan [479]	2004	The family raised concerns about the training of officers in mental health issues as Mr Kernan had been diagnosed as a schizophrenic.	Unlawful killing

No.	Name of deceased	Inquest	Family concerns	Inquest outcome wanted by bereaved
9.	Derek Bennett [401]	2004	The family had concerns over Mr Bennett's poor mental health as he had earlier been assessed as being a danger to himself and to others.	Unlawful killing
10.	Keith Larkins[481]	2005	The family was concerned about the mental health diagnosis and follow-up treatment Mr Larkins had received. The family was also concerned that the police believed he was a terrorist as the shooting occurred in the vicinity of Heathrow airport.	Not recorded on the available inquest file materials.
11.	Phillip Marsden [402]	2008	Whether proper police procedures were followed in the control room; whether police officers had been briefed correctly in respect of Mr Marsden's imitation gun?	Narrative, open, lawful killing or suicide as agreed that unlawful killing was inappropriate.

[401] Original inquest file of Derek Bennett accessed om 30/11/2018. The inquest verdict of lawful killing was later described by family members as a 'traversty of justice.' [481] Original inquest file of Keith Larkins accessed on 25/06/2018.
[402] Original inquest file of Philip Marsden accessed on 13/07/2018. [483]
Original inquest file of Terry Nicholas accessed on 15/05/2007.

No.	Name of deceased	Inquest	Family concerns	Inquest outcome wanted by bereaved
12.	Terry Nicholas[483]	2009	Whether the planning of the police operation to apprehend Mr Nicholas after he had collected a firearm had been adequate? Whether the firearms officers had sufficiently identified themselves at the time of the interception of Mr Nicholas?	Family accepted that the jury should reach a verdict of lawful killing although they wanted a number of questions left to the jury identifying any failings in the police operation.
13.	Mervyn Tussler[403]	2010	Family members or negotiators should have been used and allowed to talk to Mr Tussler	Questions to be left to the jury in respect of the absence of negotiators at the
14.	Mark Nunes [404]	2011	The family challenged the adequacy of the training for firearms officers.	scene Unlawful killing and failure or narrative as lawful killing insufficient to reflect the circumstance of the death.
15.	Andrew Markland[405]	2011	The family challenged the adequacy of the training for firearms officers.	Unlawful killing or narrative as lawful killing insufficient to reflect the circumstance of the death.

[403] Original inquest of Mervyn Tussler accessed on 25/04/2017.
[404] Original inquest file of Mark Nunes accessed on 31/03/2017.
[405] Original inquest file of Andrew Markland accessed on 31/03/2017. [487] Original inquest file of Dorothy Groce accessed 30/11/2018.

16.	Dorothy Groce[487]	2014	The family challenged the adequacy of intelligence gathered and the planning of the police search operation and the use of firearms in a family home.	No verdict of unlawful killing could be left to the jury due the firearms officer's acquittal of GBH in 1987.

9.3 Case studies

Although the following three inquests have not formed the subject of a case study due to the unavailability of access to the original file materials, they are included here as they are considered to be illustrative of how important a verdict of 'unlawful killing' is to family members, particularly where there has been no criminal prosecution and to the bereaved a lack of 'justice' for the death of their family member. Due to the high profile nature of these inquests and the legal challenges and case law that they produced, these case studies have been able to rely upon official online reporting of

the inquest proceedings, case law reports and material published by family campaigns, interest groups and media reporting.

9.3.1 Harry Stanley

Harry Stanley was fatally shot by armed police in 1999 when the chair leg he was carrying was mistaken for a gun. The first inquest held in 2002 concluded with an 'open' verdict as the only alternative verdict left to them to consider despite the family having sought the alternative of 'unlawful killing'. The verdict was later quashed after a successful judicial review brought by Mr. Stanley's family. The second inquest was held in 2004 concluded with a verdict of 'unlawful killing' which was welcomed by the family and the interest group INQUEST, which had been supporting them.[406] However, this verdict was quashed on a judicial review by the armed officers and the "open" verdict of the first inquest was reinstated as the court refused to order a third

[406] The Guardian 'Killing of man with table leg "unlawful" (The Guardian, 29 October 2004) www.theguardian.com › 2004 › oct › 29 › ukcrime1>accessed 20 October 2020.
Deborah Coles, co-director of deaths in custody campaign group Inquest, said the following 'This inquest is a vindication of the family's fight for the truth and the only just outcome of this shocking case . . . We now expect them to be prosecuted for manslaughter. We have always believed that these officers should face criminal charges'.

inquest. On this second application for judicial review, it was said that ‘Without any disrespect to the coroner, this extremely difficult case would have benefitted from judicial oversight at a higher level.”[407] However, Mr Stanley's family members continued to campaign for a criminal prosecution of the firearms officers despite the restoration of the ‘open’ inquest verdict.[408]

9.3.2 Jean Charles de Menezes

The shooting of Jean Charles de Menezes in 2005 at Stockwell Underground Station led to concerns that armed police officers had implemented a ‘shoot to kill’ policy without there having been any parliamentary oversight or approval of this strategy.

The inquest heard by Sir Michael Wright, a retired High Court judge and held in 2009 at the Oval cricket ground with increased security measures in place. The inquest concluded with an ‘open’ verdict in preference to the only alternative left to the jury by the Coroner of “lawful killing.” The bereaved family had wanted the jury to also be able to consider a verdict of ‘unlawful killing’ and had unsuccessfully sought an emergency judicial review of the coroner’s decision not to leave this verdict to the jury and staged a silent protest during the inquest when this alternative was omitted. After the inquest had concluded the family said in a statement released through the Justice4Jean campaign group:

> After three months of evidence, 100 witnesses and millions of pounds, the coroner, Sir Michael Wright, has presided over a complete whitewash. He has failed on every count of the purpose of an inquest investigation.[409]

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[407] The Guardian, ‘Court quashes table leg shooting verdict’ (The Guardian, 12 May 2005) <www.theguardian.com › 2005 › may › 12 > accessed 20 October 2020.

[408] Staff and agencies, ‘Policemen escape charges over table leg killing’ (The Guardian, 20 October 2005) <www.the guardian.com>uk>oct>20>ukcrime1> accessed 22 May 2020.
After the Crown Prosecution Service declined to charge any officer over the shooting of Harry Stanley in 1999, Mrs Stanley said ‘Today, the police officers who killed Harry Stanley - and whose accounts of the shooting were not accepted by two inquest juries - have walked away from these events without ever being brought to account in a criminal trial. The family considers that the evidence justified criminal charges.’ United Families and Friends Campaign <uff.campaign.org> accesses 22 May 2020.
[409] Mark Tran, James Strucke and agencies ‘De Menezes family criticise inquest as a ‘whitewash’ (The Guardian, 12 December 2008) <www.the guardian.com>dec>de-menezes-family-critic…> accessed 9 August 2020.

Although there had been a successful prosecution of the metropolitan police service (as a corporate body) of a single charge of breaching health and safety rules, which required it to protect the public and a successful civil claim for damages, the family of Mr de Menezes sought to achieve ‘accountability’ in the ECtHR for the death of Mr de Menezes in their challenge to the government’s decision not to instigate criminal proceedings against any of the armed firearms officers who were responsible for Mr de Menezes’ death.[410]

9.3.3 Mark Duggan

Mark Duggan was fatally shot by firearms officers on 4th August 2011 in North London. The inquest was concluded with a final hearing that was held in 2013 by HHJ Cutler, the specially appointed Assistant Deputy Coroner. At the end of the evidence the jury was left to consider conclusions of ‘lawful’ and ‘unlawful killing’ as well as ‘open’. The inquest concluded with a majority finding of ‘lawful killing’, with the minority of jury members preferring an ‘open’ conclusion. No members of the jury found that Mr Duggan had been ‘unlawfully killed’.[411] Mr Duggan's family members and supporters described the jury determination as ‘perverse’ as they believed a finding of ‘unlawful killing’ was the appropriate conclusion and one that was reflective of the highly contentious circumstances in which Mr Duggan had been shot.[412] Since the conclusion of the inquest, the family of Mark Duggan have continued with their campaign of seeking accountability for his death through the gathering of ‘new’

[410] The family of Mr De Menezes unsuccessfully took their challenge to the absence of any criminal prosecution of individual armed officers to the ECtHR. Owen Bowcott, ‘Jean Charles de Menezes: family lose fight for police officers to be prosecuted’ (The Guardian, 30 March 2016*)* <www.the guardian.com>uk-news>marc>jean-charles..> accessed 9 August 2020.

Deborah Coles, director of the charity INQUEST, said ‘The experience of the De Menezes family and their long pursuit of justice exemplifies all that is wrong with the investigation process which follows a death involving police use of force. This disappointing ruling will further undermine confidence of bereaved families in the processes for holding police to account. At its core are concerns that the rule of law does not apply to the police for abuses of power in the same way as it does to an ordinary citizen and that they are able to avoid scrutiny and accountability.’

[411] *The Queen (on the application of Pamela Duggan) v HM Assistant Deputy Croner for the Northern District of Greater London [*2017] EWCA Civ 142.

[412] Daily Mail, ‘QC Michael Mansfield was told off after jury complained about the questioning of policeman at Mark Duggan inquest’ (Daily Mail, 24 September 2013) <www.dailymail.co.ukI> accessed 9 August 2020. In the course of the inquest, the aggressive manner of questioning by the legal representative for the bereaved led to a note being passed to the coroner from the jury expressing their alarm at this manner of cross-examination.

evidence. This has been with the intention of seeking a new inquest, a finding that Mr Duggan had been unlawfully killed by the firearms officers and the criminal prosecution of the police officers responsible for firing the fatal shots would follow.[413][414]

9.4 The bereaved and 'unlawful killing'

The dissatisfaction of the bereaved family with inquests and their outcomes has not been confined to only the most high profile of these contentious inquests. The coroner's decision not to leave a possible verdict or conclusion of unlawful killing to the jury to consider has caused protest from family members and anger with the resulting outcome of 'lawful killing' in many of these contentious inquests. This disappointment with the inquest forum and the outcome of the inquest has led to family members describing the jury decision as 'Outrageous' a 'Travesty of justice',[496] and 'The outmoded and inadequate inquest system was not the place to hear this case',[415] and 'Disappointed with the verdict but not surprised'[416] as well describing the inquest as:

> An adversarial court, where all the facts come to light and could be shown clearly, would have allowed the transparency and accountability of the police and where there was significantly more chance that justice would have been seen to be done. An inquest has no teeth in matters as serious as these. If the police are going to be

[413] A recent public meeting held in December 2019 by the family and supporters of Mr Duggan, focused on the work commissioned from of a group known as Forensic Architecture. This group was commissioned to conduct a forensic modelling of the timeline and movement of central figures in Mark Duggan's shooting immediately after the hard stop of the taxi in which he was travelling before getting out and almost immediately shot by armed officers in the belief he was carrying a gun. The modelling was based solely on the evidence used at the inquest, to show that the finding of the jury that Mr Duggan had a gun that he had thrown away before being shot was unlikely to have occurred. Family campaigners hope to use this material to seek a new inquest with a different outcome and to place pressure on the CPS to reconsider its decision not to prosecute any individual officer. <www.4frontproject.orgpost>justice-for-mark-duggan> accessed 20 May 2020.

[414] WardEver.UK, 'Lawful killing' verdict returned by inquest jury (10 January 2005) <https://4wardeveruk.org/cases/adult-cases-uk/shooting/derek-bennett accessed 20 August 2020.

[415] The Murden family response to the DPP statement following the inquest, April 2008, Simon Murden – Africa Lands Trust www.fricalandstrust.co.uksimon> accessed 10 August 2020.

[416] Clare Margetson, 'IRA suspect killed lawfully, inquest rules (The Guardian, 18 February 2000) http://www.theguardian.com/uk/2000/feb/18/northernireland..cla accessed 10 August 2020.

> free to shoot to kill they should be subject to a court of law like everyone else.[417]

9.5 Interest groups

Interest groups had previously criticised the inquest forum for delivering a service from which bereaved families were effectively excluded from participation in the contentious coroner led inquests. Many of their concerns appear to have been ameliorated by the engagement of Article 2 to these inquests and the use of preliminary hearings and the early disclosure of evidence which have been put on a statutory footing by the enactment of the CJA.[418] However, the absence of automatic public legal funding for inquests allowing the bereaved to be legally represented has continued to be the focus of campaigning by those who represent the interests of the bereaved.[419] For some campaigners, the term ‘inequality of arms’ appears to be equated to the outnumbering of legal representative or representatives for the bereaved ,by the lawyers appearing on behalf of the police authority and the firearms officers. This view appears to be held without any apparent appreciation of their potentially divergent and conflicting interests that demand individual representation.[420]

Another ongoing cause for concern for interest groups has been the refusal by the investigating body to investigate these fatal shootings on the basis that a crime has been committed, despite the IPCC previously having had a policy that tended to treat officers as suspects in a murder inquiry.[421] Consequently, there is a perception that this failure to treat the firearms officers as suspects rather than as witnesses is responsible for the lack of criminal prosecutions.[422]

[417] Simon Murden Inquest. The Murden Family Response to the DPP Statement following the Inquest, April 2008, (The Murden Family 2012).
[418] Despite the provisions of the HRA and CJA the redaction of certain sensitive information and the grant of public interest immunity, continue to remain areas of concern for the bereaved families and their legal representatives.
[419] INQUEST, ‘Now or never! Legal aid for inquests’< www.inquests.org.uklegal-aid-for-inquests> accessed 11 August 2020.
[420] Inquests such as Jean Charles de Menezes, Mark Duggan and Dorothy Groce both had senior as well as junior counsel representing the interests of the family.
[421] Evidence submitted by the IPCC to the Joint Committee on Human Rights inquiry into counterterrorism policy and Human Rights, para 44, 10 (3 March 2006).
[422] INQUEST/INQUEST Lawyers Group/Police Actions Lawyers Group Briefing – March 2006 <

For interest groups, a common and long-standing complaint has been the lack of accountability of the state and its agents through the use of criminal prosecutions, which could have been addressed if the use of fatal force had been treated as a potential homicide until proven otherwise.[505] The use of the 'justification' excuse and the law on self-defence has also been criticised for allowing firearms officers to 'get away with murder' due to the 'honest but mistaken belief' defence it provides and has prompted calls for change by the bereaved and their supporters.

Previously, the Police Complaints Authority had been accused of presenting a picture of 'cronyism' as police officers were responsible for investigating other police officers, even if from different forces.[423] Similarly, the IPCC did not escape criticism, having been regarded as 'toothless' and like its predecessor, it was perceived biased towards the interest of the police officers it was responsible for investigating, as its investigators had included a large number of former police officers.[424] Complaints had also been made that the IPCC had allowed or were complicit with the police force they were investigating in releasing information to the media that was calculated to create and leave an impression of the deceased, as someone who had left the police officers with no option but to discharge their firearms.[425]

A further common concern raised by interest groups concerned the adequacy of the independent investigation and the absence of any findings of any potentially criminal behaviour by any individual firearms officer. This concern was highlighted at the inquiry into the shooting by firearms officers of Azelle Rodney where the IPCC came in for heavy criticism by the inquiry chairman for the inadequacy of its investigation.[509] Interest groups have expressed the view that the institutional unwillingness to approach

www.palg.org.uk>app>download>Fatal+shootings+. . .> accessed 9 August 2020 [505] Memorandum from INQUEST to Joint Committee on Human Rights (26 January 2004).

[423] On a number of occasions, the same police force was requested to investigate a fatal shooting carried out by its officers rather than requesting an outside force to conduct the investigation.

[424] Koos Covee, 'Deaths in police custody: no convicted officers since 1969' (open democracy, 9 August 2013) <www.opendemocracy.netopensecuritydeaths-in> accessed 22 May 2020.

[425] These accusations were raised in both the de Menezes and Duggan deaths, where the first reports to the media that de Menezes was trying to escape when challenged by an officer by jumping over the barriers at the Underground station and Duggan, who was said to have opened fire on police officers before they returned fire. Both accounts turned out subsequently to be incorrect.

police-shooting deaths as if a crime has been committed affects the whole investigatory process from the date of death to the investigation carried out by the police and independent body and through to the consideration of prosecution by the CPS and leads to a culture of impunity within the police force that is borne out in the inquests and the verdicts and conclusions.[426]

Due to the lack of criminal prosecutions of armed officers, either at the outset of the inquest or after it had concluded, interest groups have consistently vocalised their distrust of the CPS and lack of robustness in its decision making. These decisions have with few exceptions concluded that the threshold set out in its Code had not been met and a charge of murder or manslaughter was not merited. Despite the right to seek a review of the CPS decision that was introduced in 2013 the number of prosecutions of firearms officers has not increased.[427] Consequently, in the absence of criminal prosecutions of the firearms officers and the continuing perception of bias it is said to

[509] The Azelle Rodney Inquiry Report 2015 (HC 552 2013-2014) produced after a reference made under the Inquiries Act 2005 < assets.publishing.service.gov.uk › attachment_data › file> accessed 15 May 2020.

In *R(IPCC) v IPCC* [2016] EWHC 2993 the IPCC applied to the High Court seeking to quash its own investigation report into the death of Jordan Begley after the inquest found there had been significant failings in the conduct of the police. After the inquest, the IPCC reviewed its own investigation and found errors in its own guidance and in its report.

create, it has been questioned whether the CPS responsibility for deciding whether or not to prosecute police officers should remain or be removed from it.[428]

[426] INQUEST, (media release, 19 July 2012. These accusations were repeated in 2018 by INQUEST, (media release, 19 March 2018) in respect of the CPS' decision not to prosecute any officer in the death of Jermaine Baker and CPS in which it was said, 'This serves only to create a. culture of impunity, which frustrates the prevention of abuses of power ill treatment and misconduct'. .

[427] The Victims Right to Review (VRR) scheme came into effect on 5 June 2013. This scheme provides victims, including their family members the right to request a review of a CPS decision not to prosecute or to terminate criminal proceedings.

CPS, legal guidance, Police: Guidance on the Handling of Allegations of Criminal Offences against the Police, CPS, 16 August 2018. As with any case, Crown Prosecutors must be satisfied that there is enough reliable and admissible evidence to rebut the defence raised by the officer, to the criminal standard of proof. In cases where officers claim that they acted lawfully in accordance with their powers as private citizens, as police officers or as persons serving with the police, careful analysis of the following is required: the extent of the relevant power; conditions , which need to be satisfied before the power may be exercised; the way in which the officers exercised any discretion; the degree of force used in exercising the power. www.cps.gov.uklegal-guidance>police-guidance-handling> accessed 20 May 2020.

[428] Bhatt Murphy Solicitors, INQUEST and Liberty 'Response to consultation paper on Attorney General's review of the role and practises of the CPS in cases of deaths in custody' (June 2002). See also the Butler Report on the CPS which identified a need for independence to make decisions on prosecution.

Interest groups have also called into question the efficacy of the inquest in holding firearms officers to account and INQUEST has stated that it considers it to be very rare for a coroner in the absence of legal representation for the bereaved to conduct the kind of searching questions that are asked when a family is represented. The coroner has also been perceived as being biased in favour of the police authority and its firearms officers and, therefore, cannot be considered as being able to effectively question witnesses or to address families' concerns. Interest groups have also expressed the view that coroners cannot sufficiently appreciate inquests are the final opportunity for families to seek answers to their questions and concerns.[429] INQUEST has recognised the adversarialism of the inquest in its written evidence to the House of Commons Joint Committee on Human Rights:

> The suggestion put forward by the Ministry of Justice that inquests are inquisitorial, informal processes and families can represent themselves and ask questions about the death of their relative or ask others to answer their questions is a myth. Currently, an unrepresented family is presented with a bank of lawyers representing each and every person in any given case whose conduct may be open to criticism. An inquisitorial process is in fact highly adversarial and requires specialist knowledge of organisational policies and procedures and the law.[430]

As a result of the long-standing lack of confidence in the PCA and IPCC to conduct a sufficient and independent investigation; the CPS to make an unbiased and robust decision on prosecution and the coroner to hold a sufficiently inquiring inquest, interest groups have taken the opportunity of the inquest a potentially final opportunity

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for the bereaved to rigorously test the evidence relied upon and obtain the criminally sounding outcome of 'unlawful killing'. A lack of confidence has permeated all stages of the inquest process, which is routinely subject to judicial review challenges,

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[429] INQUEST: Summary of INQUEST response to the Independent Review of Deaths and Serous Incidents in police custody (undated) and the campaign for legal funding by INQUEST, Now or never! Legal Aid for inquests (February 2019) < www.inquests.org.uklegal-aid-for-inquests> accessed 11 August 2020.

[430] House of Commons Joint Committee on Human Rights, 'Enforcing Human Rights' Written evidence from INQUEST (2018) (AET0038) <publications>parliament>jtselect>jrights> accessed 16 May 2020.

particularly those concerning anonymity decisions by the coroner. INQUEST has also commented that in its view, many coroners are ill-equipped or are unaware of what is happening nationally to gain an understanding of broader policy issues. Other supporters of the bereaved have also expressed an adverse view of the coronial service:

> Coroners seem to be easily intimidated and bullied by the representatives of the state…Weak willed coroners, afraid of being judicially reviewed, are swayed by the probability of facing a legal challenge rather than by intellectual debate and legal argument. [431]

This lack of confidence in the coroner's abilities to provide an effective service is not assisted by their lack of recognition as members of the judiciary and have been described as holding 'a relatively lower judicial office'.[432] Other comments in the High Court casting doubt on a coroner's ability to deal with factually and legally complex issues combined with the prohibition on access to certain classes of information precluding and them from holding certain inquests has resulted in the transfer of more of these contentious inquests to High Court judges and more recently, to the Chief Coroner.[433] Calls for the provision of a national coroner's service, a cadre of coroners who specialise in the complex Article 2 inquests and a route of appeal to the Chief Coroner are continuing.[518]

The interest group INQUEST has previously stated that it has pushed the boundaries of the inquest system to expose the inadequate practises and systemic failings of the police forces that have contributed to these deaths at the hands of the state. Since its creation INQUEST and other like-minded supporters have sought to influence how investigations and inquests are conducted by making legal challenges to the post

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[431] Kat Craig, 51 Socialist Lawyer 15 (January 2009).
[432] *Air Accident Investigation Branch; R (Secretary of State) v HM Senior Coroner for Norfolk & BAPA* [2016] EWHC 2279 (Singh J). Where coroners were referred to as holding a "relatively lower judicial office".
[433] The London Bridge and the Borough Market attacks, which ended with the fatal shooting of the perpetrators were transferred by the respective senior coroners to the Chief Coroner for management and hearing.<www.judiciary.uk>office-chief-coroner-judge-led-in..> accessed 11 August 2020. [518] INQUEST tells Justice Committee the Coroner's Service is failing, INQUEST submission to the Justice Select Committee Inquiry into the Coroner Service, September 2020 <committees.parliament.uk>writtenevidence>pdf> accessed 26 October 2020.

incident procedures followed by armed officers after an officer shooting [434] and to the adequacy and inclusivity of the inquest process and the final hearing.[435] However, whatever the result at the final hearing of the inquest, the decision whether or not to prosecute any individual remains with the CPS, who have been said to have demonstrated 'A clear lack of political will to bring charges against police officers.'[436] Currently, INQUEST are continuing to seek a long overdue review of the Coroner's Service to tackle fundamental inequality of arms and the needs of bereaved families through the establishment of a national coroner service and the automatic grant of legal funding.[437]

9.6 'Unlawful killing' conclusions

The short-form conclusion of unlawful killing that has been retained after the enactment of the CJA introduces into the inquisitorial forum its only remaining determination that requires a criminal standard of proof.[438] However, the evidence on which such a verdict or conclusion may be based, will not have been subjected to the same evidential rules that are applied in the criminal courts, as the oral, documentary and other evidence that is utilised, requires only for it to be relevant to the ambit and subject matter of the inquest. [439] As a consequence of this variation in the rules of admissibility, evidence that is allowed to be heard in the inquest by the coroner may later be excluded in any subsequent criminal trial on the same facts. For bereaved families, this variation can lead to the irreconcilable position of an inquest jury decision

[434] *R(Duggan) v Association of Chief Police Officers* [2014] EWCA Civ 1635.
[435] Mick Ryan, Lobbying From Below (Routledge 196). INQUEST has also suggested that the perceived imbalance between the state and the bereaved should be addressed by allowing parties (families) to put their case as if a civil or criminal trial.
[436] Kat Craig, 51 Socialist Lawyer 15 (January 2009)
[437] INQUEST, 'Long overdue review of the Coroner's Service must tackle fundamental inequality of arms and the needs of bereaved families' (INQUEST, 7 September 2020). <www.inquest.org.uk › justice-committee-evidence> 10 October 2020.

[438] Until the case of *Maughan* the inquest conclusion of 'suicide' also required to be proved beyond all reasonable doubt. This standard has now been replaced with the civil standard of "on the balance of probabilities" with the likely outcome of a greater number of "suicide" conclusions, which is likely to be a source of much to the distress of families.
[439] Police and Criminal Evidence Act 1984.

of 'unlawful killing' followed by an acquittal by the criminal jury on a charge of murder or manslaughter on the other, although both based on the same facts.[440]

A justification of self-defence is commonly raised by a firearms officer during the inquest and comprises, as in the criminal courts, two questions. First, whether the officer had an honest belief, even if mistaken, that at the time they fired the fatal shot it was needed to defend themselves or another and second, if so, was the force used reasonable in all circumstances? In criminal law, the issue of reasonableness is relevant only in so far as it is a matter that may be taken into account in deciding whether an honest or mistake belief was genuinely held by the officer in question. If so, the officer is entitled to rely on that genuinely held belief, whether or not it was mistaken and regardless of whether any mistake was a reasonable one. [441]

It is this test that is applied at inquests and requires the jury to be satisfied beyond all reasonable doubt that it has not been met before reaching a determination of 'unlawful killing.' However, the justification of self-defence In civil law differs in that it requires an armed officer to show that a mistaken belief is also an objectively reasonable one.[442] Interest groups have suggested that a self-defence justification in the coronial jurisdiction should be in line with civil-law and its lower standard of proof rather than the criminal law and would therefore be more likely to lead to a greater number of 'unlawful killing' conclusions in these contentious inquests. The ECtHR has rejected this argument and has confirmed that the reasonableness of the honest belief is to be determined subjectively from the viewpoint of the person acting in self-defence at the time of the events and not as an objective standard of reasonableness.[528] Despite this ruling, in a challenge to the coroner's address to the jury where the self-defence justification was relied upon it was found by the Court of Appeal that:

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[440] At the inquest of Jimmy Mubenga, the jury returned a verdict of 'unlawful killing' having decided his death resulted from asphyxiation during his deportation. Subsequently, the security guards responsible for carrying out Mr Mubenga's deportation were charged with his manslaughter. During the course of the trial text evidence said to demonstrate the guards racist tendencies which had been
[441] Self-defence is a common law defence to offences of violence, while the defence of others is a defence recognised by section 3 of the Criminal Law Act 1967. Both defences are now governed by section 76 of the Criminal Justice and Immigration Act 2008.
[442] *Ashley and another v Chief Constable of Sussex* [2008] UKHL 25 [2008] 2WLR 975. [528] *Armani Da Silva v United Kingdom* App no 5878/08 (ECHR, 28 September 2019).

admitted at the inquest was excluded by the trial judge as being unfairly prejudicial. The security guards were acquitted much to the disbelief of his family. See also the acquittal of PC Harewood after an "unlawful killing" verdict in the inquest of Ian Tomlinson.

> There is nothing in either domestic legislation or the jurisprudence of the ECHR, which requires that in every case where a self-defence justification is raised at an inquest, a specific direction must be given to the jury that, in deciding whether a belief of imminent threat was honestly and genuinely held, the reasonableness or unreasonableness of that belief from the viewpoint of the person claiming the defence is a relevant consideration.[443]

Interest groups have recognised the differences in the rules governing the conduct of and admissibility of evidence at inquests and criminal trials but take the view that conflicts in factual or scientific evidence and the credibility of relevant witnesses will usually have been resolved to the satisfaction of the inquest jury, thereby strengthening the reasons for a favourable review by the CPS of its decision not to prosecute any firearms officer.[444] However, this view appears to be based on the assumption that all interested parties would have adopted the same adversarial style of cross-examination at the inquest as those representing the bereaved.

9.7 Adversarialism and inquests

In view of the competing interests of the interested parties and contentious circumstances in which these deaths have often occurred, the adoption of an adversarial style of cross-examination of witnesses in the pursuit of an unlawful killing determination is unsurprising. However, this adversiality presents an apparent contradiction to the coroner's initial opening statement and explanation to the jury of the fact-finding nature of the inquest, the absence of claimants and defendants and the

[443] *R(Duggan) v HM Assistant Deputy Coroner for Northern District of Greater London* [2017] EWCA Civ 142 para 80.
[444] Bhatt Murphy Solicitors, INQUEST and Liberty 'Response to consultation paper on Attorney General's review of the role and practises of the CPS in cases of deaths in custody' (June 2002).

prohibition on expressions of blame or civil or criminal liability.[445] The adversarial stance adopted by legal representatives in a contentious inquest was a cause for concern for the coroner who at its conclusion remarked that:

> Society has required the police officers to take risks on our behalf. I have subjected them to three weeks sustained attack without the protection afforded by the criminal court, with no pretence of natural justice and there is nothing I can do about it.[446]

This remark drew criticism and it was said in response:

> Amnesty International acknowledges that the coroner initially requested an inquiry into the incident. However, his expressed views reflect a failure by the authorities to provide a mechanism for a thorough and public examination of the facts and of the lawfulness of actions by state agents.[447]

Supporters of the bereaved have expressed reservations as to the adequacy of the inquest forum in which a thorough and public scrutiny of the use of lethal force by a police officer can be conducted and that provides an open, transparent and above all fair inquiry into the police actions.[448] Other interest groups have also recognised that these contentious inquests invariably end up being adversarial, as lawyers for the family seek to challenge the official version of events, while lawyers for the state seek to prevent certain lines of questioning and robustly challenge any criticisms of their clients. It has also been said that 'Over the years it has become clear that the coronal

[445] Kevin McCloughlin, Lexis Nexis, Practice Note: Procedure at coroners' inquests. www.lexisnexis.co.uklegal>procedure-at-coroners-inquest> accessed 22 May 2020. It is routine for the coroner at the beginning of a jury inquest to explain the inquisitorial nature of the inquest and its purpose as well as the jury's role within it.

[446] An Phoblacht (Online) Edition, 'O'Neill inquest disgrace, coroner warns jury not to make a 'martyr' (24 February 2000) <https://www.anphoblacht.com/contents/5913> accessed 20 May 2020.

[447] Amnesty International: UK (April 2000),AI Index: EUR 45/41/00.

[448] INQUEST, 'Death in police custody Report on the shooting of Harry Stanley (INQUEST Jene 2000 and December 2000) www.inquest.org.uk accessed 10 August 2020.

and criminal justice systems are both ill-equipped and unwilling to deliver justice and provide the answers the families need and deserve.'[449]

Despite these reservations, interest groups have continued to support the use of the inquest as an appropriate forum in which to investigate these contentious deaths. The mandatory requirement of a jury in these contentious inquests is considered to be less likely to result in matters being swept under the carpet, unlike a public inquiry where a jury is not empanelled.[450]

The interest group INQUEST has emphasised the coroner's role in limiting questions to the ambit only of the inquest demonstrates a lack of understanding that for many of the bereaved, the inquest is the only opportunity they will have to discover the truth of how their family member came to die.[451] While the courts have acknowledged that it is appropriate for witnesses in an inquest to be tested on their evidence to fulfil the fact finding role of the inquest, it has also been recognised that it can result in an extensive, aggressive and inappropriate manner of questioning witnesses, most frequently the police officer involved, whether in a planning or operational role, resulting in an adversarial hearing with the aim of securing a verdict or conclusion of 'unlawful killing' in the hope and expectation of a criminal prosecution.[452]

9.8 Coroners

It had been considered that interviews with coroners might also provide a source of insight into these contentious inquests. However, these were not pursued on the basis that the coroners from the first period of 1990 to 2000 were long retired or had themselves died or were otherwise unavailable. A small number of coroners that had

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[449] Kat Craig, 'Deaths at the hands of the state – will police officers ever be held to account?' 51 Socialist Lawyer 14 (January 2009)

[450] Catherine Fairbairn and Jack Simson Lairds, 'Inquests and Public Inquiries,' *(*HC BP/08012, 21 June 2017).

[451] INQUEST: INQUEST's response to the Ministry of Justice consultation on establishing an Independent Public Advocate December 2018, 5, para 4 <www.inquest.org.uk accessed> 13 May 2020.

[452] *R v Christopher Killick* [2011] EWCA Crim 1608. The Court of Appeal set out the rights of a crime victim to seek review a CPS decision not to prosecute.

held a contentious inquest from the second period continued in post although again many had since retired. In view of the infrequent nature of these inquests, the majority of coroners, unlike the lawyers and the firearms officers, had held more than one of these inquests and therefore assurances of confidentiality were likely to be ineffective as the inquest and the coroner were easily identifiable. Interviews with coroners also raised issues of a conflict of interest and bias, whether actual or perceived, as well as potentially compromising the efficacy of their continuing professional role in future contentious inquests. Therefore, the non-confidential information from the inquest files and other publicly available material were relied upon to record their management of these inquests and publicised remarks.

9.9 Alternatives

The adoption of the suggested two-stage approach may provide a solution in part, to the inordinate delays that these contentious inquests suffer by the holding of a short hearing that deals solely with the 'justification' issue, thereby answering at an early stage, the question that is of primary importance to many bereaved families of whether, the firearms officer honestly, even if mistakenly believed that their life or the life of another was in danger. However, the suggestion by Lawyer 'B' in Chapter Eight that this short hearing should be followed by a more lengthy one that deals with the wider circumstances to satisfy the state's Article 2 obligations, where other issues of concern could be identified and made subject to a Prevention of Future Deaths Report, is unlikely to significantly shorten the delay to concluding the contentious inquest.

It is unclear whether this two-stage approach could be successfully adapted to other Article 2 inquests is less clear. Deaths in police and prison custody may result from several consecutive acts that are carried out by more than one individual all of which contribute to a death and which may lead to critical narrative findings of 'failings' and 'neglect' by the inquest jury. Nevertheless, an early resolution of whether the deceased was 'lawfully' or 'unlawfully killed' in a police-shooting inquest may serve to diffuse suspicion and alleviate the burden placed on bereaved families and armed officers by

the continuing uncertainty and delay in the determination of ‘how’ the deceased died, notwithstanding the resolution of the wider circumstances leading to the death would remain, albeit temporarily, unresolved.

England and Wales have not been alone in attracting controversy as to manner in which deaths that have resulted from the use of force by state agents have been investigated. It has been widely accepted that firearms officers should be required to account and be held accountable for their actions in the use of fatal force in the performance of their duties, but the manner in which this might be fairly and appropriately achieved has been open to a range of interpretations on an international level.

9.9.1 Canada

As in the UK, the Canadian government has opposed the formation of a national Coroner’s service and has said that ‘Provinces are best suited to address health and coroner-related matters.”[453] Consequently, while many of Canada’s jurisdictions have retained the role of the coroner for the investigation of deaths, others have preferred the use of a medical examiner system. As in England and Wales, the efficacy of the inquest system has also come under scrutiny with calls for change, due to inquests having become increasingly adversarial and protracted, attributed to the trend of participants ‘lawyering up.’[454] There have been diverse views expressed whether inquests should retain their inquisitorial character, enhanced by the use of a lay person or medical professional presiding. Other commentators have called upon complex inquests to be judge led and another alternative has favoured a more productive approach with a starting presumption ‘that something has gone wrong’ and the need to look for solutions.[455]

[453] Douglas Quan ‘Dying to be heard: Expert views on how to resuscitate our inquest system’ (17 January 2014).
[454] Douglas Quan, ‘Dying to be heard: Expert views on how to resuscitate our inquest system, (17 January 2014).
[455] Douglas Quan, ‘Dying to be heard: Expert views on how to resuscitate our inquest system’ [542] Conor Shine, ‘Commission shelves Coroner’s inquest for new police fatality review process,’ (Las Vegas Sun, 7 January 2013).

9.9.2 The USA

The system utilised for the investigation of deaths in the USA is designated by each state and managed at the local level by the counties within it. Where the inquest forum has been retained, many states in the USA have sought to modernise it, although differences between counties, albeit in the same state, may still exist in the management of death investigations. Although many states have preferred to adopt the Medical Examiner system in replacement of the post of the coroner, there remain a number that have continued to base its system of death investigation on the inquest forum. Consequently, wide variations exist in the management of death investigation in the USA.

In 2013, Nevada's Clark County introduced a new fact-finding process into fatal officer-involved shootings known as a 'police fatality review process' and brought into use whenever the District Attorney's Office makes a preliminary ruling that a fatal officer involved shooting was not criminal.[542] This review process was replaced coroner's inquests and streamlined the death investigation process by moving the

hearings out of the courtroom and abandonment of the previously used panel comprised of members of the public that had acted as a 'jury' during inquests.[456] It was also suggested that there should be a short judge led hearing to determine the fact of the fatal shooting and which records an outcome of a 'lawful' or 'unlawful killing'. Issues of policy, procedure and operational matters would be reserved to a second and longer hearing. The use of judges as coroners would serve to lend these reviews with the level of importance they deserved.

The system of reviewing deaths at the hands of the state (deadly force) in King County, also underwent a lengthy overhaul to provide a "more fair and transparent" system after these inquests had taken on the appearance of a trial with evidence being presented by a prosecutor to a panel of jurors and presided over by a judge. These inquests were said to have invariably ended with the jury answering a series of

[456] Conor Shine, 'Commission shelves coroner's inquests for new "police fatality review process"' (Las Vegas Sun, 7 January 2013).<lasvegassun.com>news>2013>jan>07>commission> accessed 20 May 2020.

questions and finding that the officer feared for their life or the lives of others thereby implying that the death was justified.[457]

The review suggested that by providing legal representation for the bereaved more frequently and by focusing on the policies and procedures that might prevent future deaths, it would help erase a long-standing perception that the process has favoured police. It was also intended that the review would move away the inquest process from the trappings of a trial and focus on whether police followed policies and training, rather than on an officer's individual perceptions of the need to use his firearm. It was also recommended that the review administrators should be made up of retired rather than serving judges, who would preside over the inquest with an inquest panel , which would be made up of four to six members to assist.[458] However, attempts to implement a revised system of death investigation have been met by challenges from various groups of stakeholders, including bereaved families who wanted inquests to include

potential criminal charges against officers. Consequently, the inquest process remains on hold pending clarification from the courts.[459]

9.9.3 Northern Ireland

Unlike other countries in the UK, inquests in Northern Ireland are held under a national Coroner service that operates under its own laws and rules.[460] However, the inquest jury is prohibited from reaching verdicts of 'lawful' and 'unlawful killing' and is now required to make 'findings' and 'determinations', although nothing in the legislation prevents the coroner or jury from finding facts that the directly relevant to the cause of death and which may point very strongly towards a conclusion that criminal liability does or does not exist.[461] Unlike England and Wales, the standard of proof in the

[457] Mike Carter, 'King County reinstates police deadly-force inquests following overhaul' Seattle Times 30 May 2019. http://www.seatletimes.com>accessed 20 May 2020.
[458] Mike Carter,' King County reinstates police deadly-force inquests following overhaul.' (Seattle Times, 30 May 2019)<http://www.seatletimes.com>accessed 20 May 2020.
[459] King County Inquest Process.
[460] Inquests in Northern Ireland are held under the Coroners Act (Northern Ireland) 19
[461] Coroners (Practice and Procedure) (Amendment) Rules (Northern Ireland) 1980. Third timetable Form 22 (as amended). In the inquest of Daniel Carson part of the determination recorded by the jury

context of an inquest requires that any fact must be proved to the civil standard, i.e. on the balance of probabilities. However, the removal of the short form verdicts of 'lawful' and 'unlawful killing' has garnered much criticism, as it said to render almost meaningless the jury's findings where a death has occurred in contentious circumstances, whether at the hands of a state agent or another individual.

9.9.4 A therapeutic, restorative approach

It has been suggested that a therapeutic, restorative, problem-solving model could be utilised in the coroner's court to minimise the negative effects of the coroner's court process on the bereaved. Such an approach would promote a more comprehensive resolution of matters in issue, including the determination of the cause of death and the public health and safety promotion role of the coroner.[462] However, the calls for 'justice' and 'accountability' strongly suggest that only a form of retributive justice will serve to satisfy many of the bereaved families. The lack of political will by the IPCC and CPS to recommend and bring charges against individual armed officers is

blamed for the lack of criminal accountability and an implementation of the law of murder and manslaughter. Consequently, while retributive justice remains a primary goal of many of the bereaved in the contentious circumstances of a police-shooting death, demands will continue to be made for firearms officers to be held to higher criminal standards where a defence of 'justification' is raised and the application of lower standards of proof in the coroner's court, then the adversarialism of the inquest is unlikely to subside.

9.10 Conclusions

A predominant concern of the bereaved and one that appears throughout the timeline of these contentious inquests, has been the conviction from the outset that their family member has been 'unlawfully killed' as a result of the fatal force used by agents of

that, 'There was compelling and credible evidence that the injury sustained by the deceased was as a result of a bullet fired by a person identified as S1'. Summary of Findings, Judicial Communications Office 10 June 2019, Summary of Inquest Findings - Daniel Carson Inquest - 10.6.19.DOC , accessed 22 August 2020.

[462] Michael King, 'Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model' [2008] JLM 442.

the state. As a consequence of this belief the bereaved families have frequently sought from the inquest jury a determination of 'unlawful killing' in the hope that this would lead to retributive justice in the form of a criminal prosecution and conviction rather than providing a form of therapeutic justice that has been advocated.

As the degree of involvement and level of participation in the inquest by the bereaved increased due to the implementation of the HRA and its Article 2, so have the calls for firearms officers to be held accountable with a criminal prosecution. In the absence of a criminal trial the bereaved have turned to the inquest as providing a final opportunity, in which they might achieve a degree of public accountability for the loss of their family member and a prospect of a criminal prosecution through a jury determination of unlawful killing.

Groups representing the interests of the bereaved have openly admitted to adopting an adversarial approach to these contentious inquests. This stance has been justified on the basis that the investigative process has historically been biased towards the interest of the police and its officers and that the CPS has consistently demonstrated its political unwillingness to charge firearms officers with criminal offences of murder or manslaughter. The adversarial approach to these contentious inquests has also been justified on the basis that coroners lacked the skills, expertise or resources to conduct a suitably robust inquiry and one that is sufficient to investigate and support the belief of the bereaved, that the state sanctioned death of their family member was both unnecessary and unlawful. The adoption of an adversarial approach to these contentious inquests has not led to verdicts or conclusions of 'unlawful killing' or to criminal prosecutions with most these inquests having concluded with an outcome of 'lawful killing'. It has however, led to the erosion of the coroner-led inquisitorial inquest that was prevalent during the 1990's.

It has not been suggested that the bereaved should be deprived of the opportunity to play an active and informed role in the inquest of their family member or that firearms officers should not be called upon to account for their use of fatal force. However, the use of the inquest as though it were a trial, has done little to achieve the outcome desired by bereaved families, while the use of an adversarial style of advocacy has demonstrated the potential to alienate not only the witnesses that are central to

establishing the facts leading to the fatal shooting but also the coroner and perhaps, most importantly, members of the inquest jury to the detriment of the inquest process.

CHAPTER TEN: CONCLUSIONS

10.0 Introduction

At the outset of this research this thesis proposed to answer the following questions:

(i) Have inquests into deaths at the hands of the state become adversarial?

(ii) Is the implementation of Article 2 responsible for this change?

(iii) To what extent has the use of 'lawful' and 'unlawful killing' as a verdict or conclusion in inquests into contentious deaths played a role?

(iv) Do inquests into deaths at the hands of the state remain 'fit for purpose'?

Since created in the 12th Century, the coroner's court and the inquest forum have been the chosen forum in which an official investigation of an unexpected and unnatural death is conducted, for answering the core questions of 'who died, when, where and how?' However, the long established role of the inquest has undergone numerous alterations and modifications, which have included the significant curtailment of the coroner's powers and those of an inquest jury brought about by the prohibition on both the naming of any individual who was believed to be responsible for the death and the expression of an opinion on any matter, other than those required to be ascertained by the inquest.

Despite the additional requirements imposed by Article 2 on an inquest that has resulted from a use of fatal force by police firearms officers, it has remained the preferred forum in which the investigation of deaths 'at the hands of the state' is performed in England and Wales and in which in the absence of any or any sufficient criminal trial, the state's obligations under the Convention are fulfilled. Consequently, the decision to continue to use the inquest forum to satisfy the government's Article 2 obligations has ensured that the inquisitorial form of the inquest and the local nature of the coroner's court has remained an anomaly in an otherwise national adversarial legal system.

As criminal prosecutions of firearms officers have been uncommon over the timeline of this research, with none having resulted in a successful criminal prosecution for the offences of murder or manslaughter, the inquest has continued to provide the bereaved with an important forum in which to hear the detailed circumstances of how their family member died at the 'hands of the state'. Although the coroner's court is less familiar than the criminal and civil courts, several inquests that resulted from the use of fatal force by police firearms officers such as those of Harry Stanley, Jean Charles de Menezes and Mark Duggan have all contributed to raising the profile of the coroner and role of the inquest. The inquest has offered the bereaved, an opportunity to gain a public acknowledgement of the perceived unlawfulness of the death through a jury verdict or conclusion of 'unlawful killing' and the possibility of a criminal prosecution after a favourable review by the CPS of its decision not to prosecute any firearms officer.

While the requirements of Article 2 have to some extent been met by the modernising legislation of the CJA, there remains a deep dissatisfaction among the bereaved and interest groups, with the continuing absence of automatic public legal funding for these contentious inquests. This lack of funding has been perceived as denying the bereaved an opportunity to participate in the inquest on an equal footing with the police authority and its firearms officers, despite the aim of this modernising legislation to ensure the participation and active involvement of the bereaved.

The questions that this research has sought to answer, are perhaps all the more germane, considering the increased awareness of police shooting deaths in the UK the progressively vocal and widespread protests at the lack of criminal accountability on the part of police officers. The questions sought to be answered by this research, whether there has been an erosion of the inquisitorial function of inquests into staterelated deaths, and if so, whether it continues a suitable forum for the investigation forum for these, raise issues that are of concern to the bereaved and potentially, to a wider audience. A failure by the state, to provide an effective means of scrutiny of its role and those of its agents in the death of its citizens, calls into question its ability to provide the bereaved with any or any effective accountability for the death of their family member and may in turn lead to a lack of confidence in the state's policing and judicial systems.

10.1 Structure and analysis

The data and statistics about the entirety of the police-shooting deaths that occurred during the timeline of this research were collected from original inquest file material and multiple other sources, which allowed for cross-referencing and testing of the veracity of the information it contained. These data provided an important foundation from which, a structured and systematic analysis of these inquests could be conducted. A reliance on a smaller group of inquests was unlikely to have provided a large enough collection of data from which comparisons could be made. In addition, dependence solely on a qualitative approach would have been unlikely to have provided sufficient material for this research, in view of the age of these inquests and the sensitivity of their subject matter. In any event, the sensitive, highly personal and frequently confidential nature of the subject matter, with the localised nature of the coroner's service placed numerous difficulties in the way of the collection of both the quantitative and qualitative data.

The restriction of the definition of deaths that occurred 'at the hands of the state' for this research, to those that had resulted from a fatal police shooting enabled comparisons to be made both between the inquests that were held during the same period and those that were held in different periods of the coronial service. This analysis would not have been possible were the category of contentious deaths to have included all deaths that occurred over the timeline of this research that were categorised as having occurred 'at the hands of the state' and would have prevented the drawing of conclusions from which the questions posed by this research could be answered.

10.2 The 'old' approach of the 1990's

While the heavily criticised 1980's legislation remained in force during the decade of the 1990's, the coroner continued to use the wide discretionary powers it afforded for managing the inquests. Consequently, the coroner frequently made decisions with little recourse to the views of the interested parties, that went to the crux of the inquest and which dictated the tone, the degree of transparency and the efficacy of the inquest. This style of decision-making proved particularly disadvantageous to the bereaved, who, unlike the armed officers and their police employer had little or no knowledge

of, or involvement with the events that were central to the inquest and who, therefore, were reliant on its final hearing to inform them of how their family member had died.

The marginalisation of the bereaved by the coroner's approach to these contentious inquests, was demonstrated in most of the case studies from this period by the coroner's refusal to provide disclosure of documentary evidence and on occasion, a copy of the witness list to the bereaved. Although not all original file materials could be accessed for the entirety of the inquests that were concluded in this period, it was reasonable to infer from the expeditious concluding of most these, with their short final hearings, that a similar coroner led and exclusionary approach had been adopted in their management and hearing.

Consequently, the absence of any meaningful opportunity to shape the ambit of the inquest, to request copies of reports and statements, propose witnesses or prepare questions for the final hearing allowed the coroner to conduct and conclude these contentious inquests with minimal delay. In the absence of the bereaved's involvement in the preparatory stages of the inquest and their enforced inability to make informed challenges to the evidence, this approach to these contentious inquests maintained and reinforced the established coroner led, inquisitorial function of the inquest under the provisions of the 1980's coronial legislation.

10.3 The impact of Article 2

The individual circumstances in which each police-shooting death occurred and the continuing local nature of the coronial service with its idiosyncrasies of approach and the differences in the financial support provided by the responsible local authorities accounted for several variances between these contentious inquests. However, the enactment of the Human Rights Act and the automatic engagement of Article 2 to an inquest, where a state-related death had occurred was the catalyst responsible for requiring the employment of a more consistent by the coroner to these contentious inquests. Article 2 also demanded the active inclusion of the bereaved in the inquest of their family member from which they had previously been effectively excluded, although the ongoing and historic limitations on public legal funding for inquests remained to the detriment of the bereaved.

Although the coroner's legislation of the 1980's continued in force during this period of contentious inquests, the unilateral approach to decision-making that the Coroner had previously employed was constrained by the more demanding requirements of Article 2. While retaining the wide discretionary powers afforded under the Coroners Act 1988 and The Coroners Rules 1984, their use was ameliorated by Article 2 as the Coroner was required to widen the ambit of the investigation to include issues of planning, policy and procedure. The inclusion of these matters for consideration in the inquest established these contentious inquests among some of the most factually, evidentially and legally complex. Preparation for a final hearing remained fluid due to the ongoing nature of the acquisition of evidence and the availability of witnesses and other non-documentary evidence in the form of audio recordings and CCTV footage and even the identification of a suitable alternative venue in which to hold the final hearing. Therefore, multiple preliminary hearings were frequently required to ensure that all of the relevant issues affecting the final hearing had been decided and that all interested parties had been provided with the opportunity to be properly included and engaged in the process.

Where previously these same issues had been decided with minimal input from the interested parties, they were now the subject of frequently competing and opposing arguments from the interested parties at preliminary hearings and which on occasion led to a judicial review challenge initiated by the interested party, whose interests were adversely affected by the coroner's decision. The case studies of this period demonstrate that the investigative obligations of Article 2 were met by the Coroner with the holding of one or more preliminary hearings to ensure compliance with its requirements although they contributed to the lengthening delays before a final hearing could be held and the inquest concluded. These delays were also further adversely impacted by and attributable to, the time taken for completing independent investigations of the PCA and IPCC and decision making of the CPS, all of which were required to be Article 2 compliant. Consequently, the holding of the final hearing for a large number of contentious inquests concluded in this period and which have been documented in the case studies and from alternative sources, were subject to increasingly length delays of years in contrast to those of the earlier period that were measured in months

During this period of Article 2 contentious inquests that required the active inclusion of the bereaved to be considered compliant, difficulties continued with the lack of automatic availability of public legal funding for the family members, whether at the preliminary stages or for the final hearing. Although some legal funding provision was made for representation at an inquest, this was the exception rather than the norm. Consequently, bereaved families frequently remained reliant on the pro bono services provided by lawyers sympathetic to their interests to attend the preliminary stages and to represent them at the concluding hearing. Even where public legal funding was made available, families perceived there to remain an inequality of arms due to a disparity between the number of lawyers that separately represented the interests of the police authority, those of its firearms officers and those that represented their own.

Due to the expansion of the ambit of these contentious inquests and the necessary participation of the bereaved, the final hearing grew increasingly lengthy in contrast to those of the earlier period, which were concluded by the coroner with a final hearing that lasted only three to five days. Consequently, the requirements of Article 2 diluted the coroner's discretionary powers, with the coroner led questioning of the earlier period, being replaced by an increasingly adversarial style of cross-examination of police witnesses by legal representatives for the family.

10.4 Modernisation of the coronal service

Although, the adversarial sounding 'parties' and 'verdicts' had been replaced in the modernising legislation of the CJA, the Article 2 requirements of preliminary hearings and the disclosure of evidence to interested persons meant that neither the delays in concluding the contentious inquests or the length of the final hearings were noticeably lessened, despite the transference of several these inquests to a High Court judge for their management and hearing. Despite the bereaved having been placed 'at the heart of the inquest' the continuing lack of the automatic grant of public legal funding for these contentious inquests has remained problematic for the bereaved. Nonetheless, most bereaved families were able to secure representation for the final hearing, whether through the grant of legal funding, pro bono representation, by way of private means or crowd funding. Consequently, the data collected in respect of the inquests concluded since the coming into force of the CJA has given no indication that these inquests, like those held after the application of Article 2, have reverted to the

inquisitorial and coroner led inquests of the past and like them, have failed to conclude with a finding of ‘unlawful killing.’

10.5 The adversarial inquest

The belief frequently held by bereaved families that their family member has been unlawfully killed as a result of the fatal force used by the state’s agents has been a theme that has appeared throughout the timeline of these contentious inquests. Consequently, the importance of the inquest should not be underestimated, as in the absence of a criminal trial it is virtually the only forum in which, the bereaved family can acquire information about the death of their family member and where the circumstances of the death are submitted to official scrutiny. However, as the families’ reliance on the inquest has grown due to the absence of criminal proceedings, so has there been a tendency by the bereaved that has been demonstrated in the case studies and the original file material, to seek from it, an ‘unlawful killing’ determination that has not been possible to achieve elsewhere both as a public acknowledgement of their own views on the unlawfulness of the firearms officers’ actions as well providing support for their hope that the inquest will have provided sufficient evidence and material for a criminal prosecution.

The adoption of a defensive stance and a perceived unwillingness by the police authority and its firearms officers to accept an open and transparent approach to the inquest, has served as the justification for the adversarial style of advocacy that the legal representatives for the bereaved have adopted. The impact Article 2 on the procedural and substantive elements of the inquest, has allowed the bereaved to shape the nature and extent of the inquest, to prepare for its final hearing, to make challenges to official accounts of their family member’s death and to offer their own version of events. Consequently, other users of the coroner's court and participants in these contentious inquests consider them, to have grown increasingly adversarial, both in their tone and style to an extent that has caused concern among witnesses and members of the jury alike. The not uncommon decision to make a judicial review challenge that interrupts the final hearing has done little to dilute this adversariality of approach.

For many of the firearms officers that were interviewed, the theme of fairness of treatment was an issue of paramount importance to them. For the firearms officers,

the concept of 'fairness' translated into being treated, not as a suspect in a criminal offence, but as a witness from the outset of and throughout the independent investigation and ending with the conclusion of the inquest. The suggestion by interest groups, that firearms officers should automatically be treated as suspects after a fatal shooting was regarded as naïve and damaging to the interests of the bereaved, as firearms officers were more likely be concerned with their own legal rights than providing investigators with detailed accounts of events without first seeking their own legal advice and representation.

The view that an inquest is an adversarial forum and should be regarded as such was shared among many of the firearms officers. Several of these officers had prepared for the inquest in which they had been involved as if it were a trial, even if no criminal or civil penalty could be imposed. Officers also recounted the overly adversarial and 'grandstanding' approach of the bereaved's legal representatives, which appeared as being unhelpful to the inquisitorial nature of the inquest. Despite these misgivings about their treatment by the investigators and legal representatives for the bereaved, none of the firearms officers suggested that they should not be required to give an account of their role in the death of another, in the course of carrying out their duties on behalf of the police authority by whom they were employed although expressed the view that the lengthy delays in concluding these inquest were damaging to themselves as well as the bereaved due to the uncertainty and anxiety they created.

The lawyers interviewed had extensive experience of these inquests and shared similar concerns to those of the firearms officers as to lengthy, frequently inexplicable delays that had occurred before many of these inquests had been concluded. Lawyer's views on coroners were divided with some acknowledging that the inquests had been conducted well, despite the difficulties presented by limited physical and financial resources although another criticised coroners for their lack of understanding of the bereaved's interests.

Two of these experienced lawyers shared the view of the firearms officers that these controversial inquests had developed into an adversarial hearing, rather than providing the inquisitorial fact finding 'no blame' forum it had been intended to provide. The personal attacks on the character and credibility of firearms officers were considered

to have damaged the purpose of the inquisitorial inquest, to the detriment of all. The pursuit of an 'unlawful killing' outcome regardless of the evidence was also considered as having contributed to undermining the inquisitorial role of the inquest as well as providing the bereaved with unrealistic expectations of what might be achieved from it.

The bereaved have perceived a contentious inquest as a 'them and us' situation in which, the police authority and its officers have been joined by a coroner overly sympathetic to their interests. Groups representing the interests of the bereaved have openly admitted to the adoption of an adversarial approach to these contentious inquests. This adversarialism has been justified on the basis that the independent investigative process has historically been biased towards the interest of the police body and its officers and the CPS has consistently demonstrated its political unwillingness to charge firearms officers with criminal offences of murder or manslaughter. In addition, the lack of a coroner who was sufficiently attuned to the needs and concerns of the bereaved and able to rigorously challenge the official version of events justified the adversarial style of cross-examination of certain and in their pursuit of an 'unlawful killing' determination that the coroner had not otherwise been able to provide.

These contentious inquests have been intended to provide a coroner led inquisitorial hearing with the duty of the coroner to ensure the fairness of the inquest proceedings for all interested persons and the participation of the bereaved. Although it has been suggested that coroners can be equipped with training to control inquest proceedings and unruly lawyers, these suggestions ignore the criticisms made and the views held by those representing the interests of the bereaved, that interventions by the coroner are the actions of someone who does not understand the importance of the questions asked in cross-examination and who cannot be relied upon to ask searching questions of police witnesses or who are otherwise not up to the task of ensuring an Article 2 compliant inquest is held.

The courts and official publications have repeatedly emphasised that an inquest is an inquisitorial forum as there are no parties and therefore no 'case to put'. However, this view of the inquest has not been the experience of the bereaved, the firearms

officers or the legal representatives. The case studies and the interviews demonstrate that there is agreement among those who have been participants in these contentious inquests, that in reality they have become adversarial. This growth in adversarialism can be attributed to the engagement of Article 2 to these police-shooting deaths, its requirement of ensuring the participation of the bereaved in the investigation of the death and any inquest and implemented using preliminary hearings, the now mandatory pre-inquest disclosure of evidence and their active participation in the final hearing.

10.6 'Lawful' and 'unlawful killing'

Despite the replacement by the CJA of the adversarial terminology that referred to 'parties' and 'verdicts' with the use of non-adversarial sounding 'interested persons' and 'conclusions,' this modernising legislation retained the use of lawful and unlawful killing in the short form conclusions available to the coroner and an inquest jury. A determination of 'unlawful killing' had long been of central importance to bereaved families as a means of support to their firmly held views that their family member had been the subject of a state-sponsored killing, that steps to prevent the fatal shooting could and should have been taken by the police authority and its officers and that the death could have been avoided by the use of non-lethal methods.

Consequently, the retention of these conclusions has done little to emphasise the supposedly inquisitorial nature of the inquest, as a verdict or conclusion of 'unlawful killing' has been equated by a bereaved family to a finding of 'guilt'. This outcome to an inquest has also contributed to the raising of an expectation among the bereaved, that a review by the CPS of its decision not to prosecute will follow and that a subsequent criminal trial on the same facts would be likely to result in a conviction. The concerted efforts of the bereaved to secure a determination of 'unlawful killing' has however failed to alert the bereaved to the likelihood of an acquittal in the more evidentially and procedurally rigorous confines of the criminal courts and the unqualified right of a defendant to a 'fair hearing' that is provided by Article 6 of the Convention.

The absence of criminal prosecutions led to unsuccessful challenges to the justification of 'self-defence' relied upon by firearms officers and a failure to comply with Article

2 in the absence of criminal prosecutions in the ECtHR. Notwithstanding this lack of success in the courts, family campaigns have continued to seek retributive justice for the death of their family member. This has included the pursuit of a second inquest in the hope that a conclusion of 'unlawful killing' will be secured and a criminal prosecution and conviction will follow, thereby contributing to the use of the inquest as an adversarial forum rather than its intended inquisitorial purpose.

10.7 Fitness for purpose

A verdict or determination of 'lawful killing' does not appear to satisfy the degree of accountability that the bereaved family require for the death of their family member. The bereaved have demonstrated a determination to pursue an outcome of 'unlawful killing' as a form of public acknowledgement of the unlawfulness of a death and the possibility of criminal proceedings. Despite the adoption of an adversarial approach to these contentious inquests it has not led to a jury determination of 'unlawful killing' or to criminal prosecutions as the inquests in the timeline of this research have with few exceptions, concluded with an outcome of 'lawful killing.'

It has been demonstrated that at each stage of the independent investigation and subsequent inquest, there have been elements of mistrust, suspicion and misunderstanding among the groups of interested persons. The view often erroneously held by the bereaved families, that the interests of police authority and its officers have been precisely aligned has manifested in their perception that the state has been unfairly over-represented by lawyers at these contentious inquests. However, the calls for legal funding to allow for legal representation for a wider number of family members at the inquest, as a means to achieve an equality of arms to remedy this imbalance, are unlikely to diminish the growth of adversarialism in the inquest forum.

Bereaved families and the firearms officers under investigation, have indicated that there has been a lack of confidence in the thoroughness and impartiality of the independent investigation and the quality of the completed report, on which the subsequent inquest is primarily based, with both groups having criticised the excessive delays that have occurred in concluding these investigations. As a consequence of the application of Article 2 to these investigations and inquests, the first preliminary inquest hearings have often been held more than a year since the death was reported

to the coroner with several years elapsing before the inquest has been concluded. Added to this extensive period of delay is a lack of confidence in the capabilities and independence of the coroner and an unmet expectation of how an inquisitorial hearing should be held and a mistaken expectation as to what can be achieved by it.

It has not been suggested that the bereaved should be deprived of the opportunity to play an active and informed role in the inquest of their family member, or that firearms officers should not be called upon to account for their use of fatal force. However, the use of the inquest as though it was a trial has done little to provide the outcome desired by many bereaved families. In addition, the use of an adversarial style of advocacy has demonstrated the potential to alienate not only witnesses that are central to establishing the facts leading to the fatal shooting but also the coroner and importantly, members of the inquest jury. These factors have contributed to the erosion of the inquisitorial nature of the inquest and leads to the conclusion that the inquest forum no longer meets the expectations of either the bereaved, the state or its agents and that reform or an alternative is required.

10.8 Conclusion

This thesis has established that despite the repetition by official sources that the inquest is a 'no blame' inquisitorial forum, this is not borne out by the contentious inquests or the experiences of the participants. Although, the bereaved had previously been unable to actively participate in the inquest of their family member due to the limitations of the 1980's coronial legislation, the implementation of Article 2 saw these restraints removed. As a consequence of this, family members have been enabled and are encouraged to become actively involved in all stages of the inquest in which they have become more vocal in their challenge to the official version of events. This thesis has established that these contentious inquests are effectively adversarial with the bereaved on one side and the police authority and its firearms officers on the other. This adversarialism is continued by the determination of the bereaved and their supporters to secure an outcome of 'unlawful killing' as a step towards the retributive justice that is provided by the criminal courts.

Despite the documented and continuing difficulties with the investigations into these state-related deaths, the requirement for of an official and effective form of death

investigation into those who die ‘at the hands of the state’ is recognised and accepted by those at the centre of them. The importance of such an investigation cannot be under-estimated as the social tension that can arise after the use of fatal force by police officers has been demonstrated by widespread protests in the UK. However, in the absence of criminal prosecutions and convictions, the bereaved have used the opportunity of the inquest to understand how their family member died at ‘the hands of the state’ and to achieve public recognition of their loss.

The retention of a conclusion of ‘unlawful killing’ in the inquest forum has contributed to an adversarial approach to these inquest as it has been viewed by the bereaved as a potential solution to the lack of a prosecution and the absence of criminal accountability. As a consequence, the fact finding, ‘no blame’ forum of the inquest has been replaced with a trial like procedure in which, the evidential rules of the adversarial courts do not apply. However, the ramifications of a finding of ‘unlawful killing’ in an inquest are likely to be of significance for both the police authority and its firearms officers and provides a reason for seeking to avoid such an outcome.

The difficulties encountered in England and Wales with the form of inquests into fatal police shootings have been mirrored in the experiences of other countries that share a similar system of death investigation and for which reviews and alternatives have been sought, with none providing an answer that sufficiently satisfies the expectations of all participants. This research has identified that inquests into police-shooting deaths provide an inadequate forum for these police-shooting deaths to the dissatisfaction of the bereaved and the firearms officers alike.

The investigative requirements of Article 2 demand an effective forum which can function to the satisfaction of all interested persons. In order to achieve this, it is necessary to consider how the encroachment of adversariality in these inquests arising from shootings by firearms officers and in other inquests where Article 2 is engaged could be overcome, either by the retention of an inquisitorial format or expressly acknowledged and accommodated as part of an adversarial process. Either scenario would necessitate government involvement and extensive consultation with the local authority providers of their local coronial service as well as the wide range of

stakeholders that are involved where a death has occurred at the hands of the state, whether directly as interested persons or indirectly as interest and support groups.

In the event that consensus were achieved on how best to investigate deaths where 'the right to life' is engaged, it is likely that significant legislative and procedural changes would be required, whether it is for the implementation of either an openly adversarial forum or the retention of a revised inquisitorial format. Were an openly adversarial approach to be adopted, coroners would require more training and the provision of more extensive powers as regards the conduct of the proceedings and the admissibility of evidence. If the inquisitorial approach remains in place, lawyers and other representatives would be required to be more controlled in their approach to these inquests and coroners provided with increased funding that would allow them to carry out to a greater extent their investigatory role in order to reduce the dependency on IOPC reports other investigatory body.

The conclusions reached in this thesis justify the carrying out of further research into whether the historic forum of the inquest should continue to be used to investigate police shooting deaths as well as deaths that have occurred after other forms of state contact. In addition, research into the viable alternatives to the inquest in staterelated deaths may be of value to all stakeholders who are required in the future to participate in these investigations.

APPENDIX 1

ARTICLE 2 OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS AS INCORPORATED INTO THE HUMAN RIGHTS ACT 1998 UNDER SCHEDULE 1.

Article 2 Right to life

1 Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2 Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the

(c) in action lawfully taken for the purpose of quelling a riot or insurrection.

APPENDIX 2

ARTICLE 6 OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS AS INCORPORATED INTO THE HUMAN RIGHTS ACT 1998.

Article 6 Right to a fair trial

1 In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2 Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3 Everyone charged with a criminal offence has the following minimum rights:

(a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;

(b) to have adequate time and facilities for the preparation of his defence;

(c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

(e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court.

APPENDIX 3

RESPONSES TO REQUESTS FOR ACCESS TO INQUEST FILES:

NO.	NAME OF DECEASED	DATE REQUESTS MADE	CORONER'S REGION OR AREA
1.	Michael Alexander	September 2018 November 2018	West London
2.	Kenneth Baker	September 2018 November 2018	Surrey
3.	Ian Gordon	June 2018 September 2018 November 2018	Shropshire, Telford & Wrekin
4.	Derek Wallbanks	June 2018 September 2018 November 2018	Newcastle on Tyne
5.	Keith Carrott	Jurisdiction not known	N/A

6.	Ian Bennett	March 2017 June 2018	West Yorkshire Western
7.	Barry Clutterham	June 2018 September 2018 November 2018	Suffolk
8.	Peter Swann	September 2018 November 2018	South London
9.	David Luckhurst	September 2018 November 2018	Hertfordshire
10.	Ian Hay	November 2018	Plymouth, Torbay and South Devon
11.	David Stone	June 2018	Inner North London
12.	Robert Dixon	March 2017	West Yorkshire (Western)
13.	John O'Brien	March 2017	Inner North London
14.	David Howell	March 2017	Birmingham & Solihull

NO.	**NAME OF DECEASED**	**DATE REQUESTS MADE**	**CORONER'S REGION OR AREA**
15.	James Brady	March 2017 June 2018 September 2018 November 2018	Newcastle upon Tyne
16.	Michael Fitzgerald	March 2017 June 2018	Bedfordshire and Luton
17.	Diarmund	March 2017	West London

	O'Neill	June 2018	
18.	Antony Kitts	March 2017 September 2018 November 2018	Cornwall and the Isles of Scilly
19.	Michael Fitzpatrick	September 2018 November 2018	Brighton and Hove
20.	Steven Dickson	March 2017 June 2018 September 2018 November 2018	Derby & Derbyshire
21.	Patrick (Kieron) O'Donnell	June 2018	Inner North London
22.	Kirk Davies	March 2017 June 2018 September 2018 November 2018	West Yorkshire Eastern
23.	Michael Malsbury	March 2017	North London
24.	Derek Bennett	September 2018	Inner South London
25.	Andrew Kernan	March 2017	Liverpool and the Wirral
26.	Jason Gifford	September 2018 November 2018	Buckinghamshire
27.	Colin O'Connor	September 2018 November 2018	Bedfordshire and Luton
28.	Philip Prout	March 2017 September 2018	Plymouth, Torbay & South Devon
29.	Fosta Thompson	March 2017 June 2018 September 2018 November 2018	Avon
30.	Keith Larkins	March 2017 June 2018	West London
31.	Harry Stanley	March 2017	East London
32	Nicholas Palmer	March 2017 June 2018 November 2018	South London

NO.	NAME OF DECEASED	DATE REQUESTS MADE	CORONER'S REGION OR AREA
33.	Craig King	March 2017 June 2018 September 2018	Manchester South
34.	John Mark Scott	March 2017 June 2018 September 2018 November 2018	Northumberland South
35.	Phillip Marsden	March 2017 June 2018	Staffordshire South
36.	Derek Bateman	March 2017 June 2018 September 2018 November 2018	Surrey
37.	Simon Murden	March 2017 June 2018 September 2018 November 2018	East Riding of Yorkshire and Hull
38.	Jean Charles de Menezes	Available online	Inner North London
39.	David Sycamore	March 2017 June 2018 September 2018 November 2018	Surrey
40.	Terry Nicholas	March 2017 June 2018	West London
41.	Robert Haines	March 2017 June 2018 September 2018 November 2018	Central and South East Kent
42.	Mark Saunders	March 2017	Inner West London
43.	Ann Sanderson	March 2017 June 2018 September 2018	North West Kent

		November 2018	
44.	Mervyn Tussler	March 2017	West Sussex
45.	Dayniel Tucker	March 2017 June 2018 September 2018 November 2018	North West Kent
46.	Alistair Bell	March 2017	West Yorkshire (Western)
NO.	**NAME OF DECEASED**	**DATE REQUESTS MADE**	**CORONER'S REGION OR AREA**
47.	Andrew Hammond	March 2017	East London
48.	Keith Richards	March 2017	County Durham and Darlington
49 & 50.	Mark Nunes & Andrew Markland	March 2017	Wiltshire and Swindon
51.	Mark Duggan	Available online	North London
52	Dean Joseph	March 2017	Inner North London
53.	Dorothy Groce	March 2017	Inner South London
54.	James Fox	March 2017	North London
55.	Richard Davies	Lawful killing	Cambridgeshire and Peterborough
56.	James Wilson	Available online	Newcastle upon Tyne
57.	William Smith	Inquest ongoing	Kent North West

KEY:

Access refused

Access given
Access not requested as details available online or from press reports
No response from coroner but details available from press and law reports
Inquest ongoing – final hearing not yet held
Region not known

APPENDIX 4

Information sought from the inquest files:

1. The identity and number of Properly Interested Parties (PIPs) or Interested Persons (IPs).

2. The ambit of the inquest?

3. If IPs or PIPs were legally represented?

4. The number of witnesses (oral & documentary) called to give oral evidence or gave "read" evidence.

5. If Rule 22 (right not to incriminate yourself) was utilised?

6. Other evidence used at the inquest e.g. CCTV, surveillance footage.

7. The number of pre-inquest review hearings (PIRH) held in preparation for the inquest.

8. Pre-inquest disclosure – what and to whom given and when?

9. Legal questions arising both at the preliminary stages and the substantive inquest, e.g. application for Public Interest Immunity, anonymity of witnesses.

10. The time taken to hear the inquest.

11. The submissions by PIPs/IPs as to the verdicts or conclusions that can be left to the jury.

12. Whether there was a Prevention of Future Death Report following the conclusion of the inquest.

APPENDIX 5

Questions asked in interview of the firearms officers:

1. What is your background as an armed police officer?
2. What (contentions) inquests have you been involved in?
3. What was the extent of that involvement?
4. For each inquest identified at Q.2 what is your opinion of:

(a) The inquest (its preparation and the final hearing)?

(b) The other interested parties?

(c) The coroner?

(d) The nature of the questioning ?

(e) The verdict/conclusion?

APPENDIX 6

Questions asked of the lawyers in interview:

1. Have you participated at any inquests in the following periods where the deceased has died as a result of a shooting by armed police officers?:

    (a) 1990 to 2000

    (b) 2001 to 2012

    (c) 2013 to 2018

2. Which inquest, when and what police force?
3. What was the coroner's jurisdiction for each of the inquests identified?
4. Which person(s) did you represent?
5. Did you attend any pre-inquest review hearings?
6. If yes, how many?
7. If no, what was the reason?
8. What was decided at the pre-inquest review hearings?
9. Were preparations for the final inquest hearing adequate?
10. If not, why not?
11. Did your client give evidence at the inquest?
12. What was the verdict/conclusion at the inquest?
13. Did you think this verdict/conclusion was appropriate?
14. What are your thoughts in the way the(se) inquests was/were (i) prepared for and (ii) conducted.
15. An inquest is an inquisitorial fact-finding investigation of the circumstances leading up to the death, it is not intended to be adversarial. Does this statement accord with your direct or indirect experience?
16. Please explain your answer to question number 15.
17. Were you satisfied with the outcome of the inquest?
18. Please explain your answer to question 17.
19. Is there anything you would change about the way inquests into contentious deaths are conducted? If "yes", what?
20. Any other relevant comments?

BIBLIOGRAPHY

BOOKS

Baker D,
Deaths after Police Contact: Constructing Accountability in the 21st Century (1st edn, Palgrave Macmillan 2016)

Beggs J and Davies H,
Police Misconduct, Complaints, and Public Regulation (1st edn, Oxford University Press 2009)

Bronitt S, Gani M and Hufnagel S (eds),
Shooting to Kill: Socio-Legal Perspectives on the Use of Lethal Force (Hart Publishing 2012)

Cooper J,
Inquests (1st edn, Hart Publishing 2011)

Cross C and Garnham N (eds),
The Inquest Book: The Law of Coroners and Inquests (Hart Publishing 2016)

Dorries CP,
Coroners' Courts: A Guide to Law and Practice (3rd edn, Oxford University Press 2014)

Foster S,
Human Rights and Civil Liberties (3rd edn, Pearson Education Ltd 2011)

Freckelton IR and Ranson D,
Death Investigation and the Coroner's Inquest: Law, Medicine & Practice (South Melbourne, Oxford University Press 2006)

Green J and Green M,
Dealing with Death: A Handbook of Practices, Procedures and Law (2nd ed, Jessica Kingsley Publishers 2006)

Hoffman D and Rowe J,
Human Rights in the UK: An Introduction to the Human Rights Act 1998 (4th edn, Pearson 2013)

Honneth A,
The Struggle for Recognition. The Moral Grammar of Social Conflicts (English translation, Polity Press 1996)

Human Rights Watch,
Racist violence in the United Kingdom (Human Rights Watch: Helsinki 1997)
Hunnisett RF,
The Medieval Coroner (Cambridge University Press 2008) (private printing 2018)

Impey J,
The Practice of the Office of Coroner, (5th edn, London 1825, private printing))

Ingleton R,
Arming the British Police: The Great Debate (Taylor & Francis Ltd 1997)

Institute of Race Relations,
Deadly Silence: Black Deaths in Custody (Institute of Race Relations 1991)

Institute of Race Relations,
Dying for Justice (Institute of Race Relations 2015)

King M, Freiberg A, Batagol, B and Hyams, R,
Non-Adversarial Justice (2nd edn. The Federation Press 2014)

van Koppen P and Penrod SD (eds),
Adversarial versus Inquisitorial Justice: Psychological Perspectives on Criminal Justice Systems (Springer US 2003)

Leckey JL and Greer DS,
Coroners' Law and Practice in Northern Ireland (SLS Legal Publications (NI) 1998)

Leverick F,
Killing in Self-Defence (Oxford University Press 2006).

Levine M and Pyke J,
Levine on Coroners' Courts (Sweet & Maxwell 1999)

Long T,
Lethal Force (Penguin Random House 2016)

Matthews P,
Jervis on Coroners (14th edn, Sweet & Maxwell 2019)

Robertson G,
The Justice Game (Chatto & Windus 1998)

Ryan M,
Lobbying From Below: Inquest in Defence of Civil Liberties (1st edn, Routledge 1996)

Sampson K and Hillsborough Justice Campaign,
Hillsborough Voices: The Real Story Told by the People Themselves (Ebury Press 2016).

Scarman G,
The Scarman Report: the Brixton Disorders 10 - 12 April 1981: report of an Inquiry (Penguin 1986)

Scraton P,
Hillsborough - The Truth (Mainstream Publishing 2009)

Scraton P and Chadwick K,
In the Arms of the Law: coroners' Inquest and Deaths in Custody (Pluto 1987)

Selby H,
The Inquest Handbook (Federation Press 1998)

Shaw H and Coles D,
Unlocking the Truth - Families' Experience of the Investigation of Deaths in Custody (INQUEST 2007)

Smith S,
Stop! Armed Police!: Inside the Met's Firearms Unit (Robert Hale 2014)

Squires P and Kennison P,
Shooting to Kill?: Policing, Firearms and Armed Response (Wiley-Blackwell 2010)

Thomas L, Straw A, Machover D and Friedman F,
Inquests: A practitioner's guide (3rd edn, Legal Action Group 2014).

Waldren MJ,
Armed Police: The Police Use of Firearms since 1945
(The History Press 2007)

Walen A and Zalta E (ed)
Walen, Alec*, "Retributive Justice"* Stanford Encyclopaedia of Philosophy (Fall edn, 2020)

Walker S and Archbold C,
The New World of Police Accountability (2nd edn, SAGE Publications 2014)

Weissbrodt D,
The right to a fair trial under the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights (Martinus Nijhoff 2001)

Zweigert K and Kötz H,
An Introduction to Comparative Law (Tony Weir tr, 3rd edn, OUP 1998)

OFFICIAL PUBLICATIONS

Brodrick N,
Report of the Committee on death certification and coroners
(Cm 4810, 1971
HMSO, 1971), ISBN: 0101481004

Butler G,
Inquiry into Crown Prosecution Service Decision-Making in Relation to Deaths in Custody and Related Matters (HH QC Gerald Butler)
(TSO August 1999)
ISBN: 011 341236 3

Crown Prosecution Service,
The Code for Crown Prosecutors, 8th Edition, October 2018
<www.cps.gov.uk>publication>code-crown-prosecutors> accessed 27 July 2020

College of Policing,
Code of Practice on Armed Policing and Police use of Less Lethal Weapons (January 2020)
<www.gov.uk/official-document> accessed 15 May 2020
ISBN:978-1-5286-1724-6

Coroners Society of England and Wales,
Memorandum submitted by Coroners Society of England and Wales (CTB 4) (8 April 2008)
<publications.parliament.uk>memos>ucm0402> accessed 22 June 2020

Courts and Tribunals Judiciary,
Coroners
<www.judiciary.uk>the-justice-system>coroners> accessed 20 October 2020

Courts and Tribunals Judiciary, Mergers of Coroner Areas
<www.judiciary.uk>office-chief-coroner>mergers-of-> accessed 12 May 2020

Council of Europe,
Treaty Office,
<www.coe.int>Conventions>Full list>accessed 12 May 2020.

Crown Prosecution Service,
Agreement between The Crown Prosecution Service, The National Police Chiefs' Council, The Chief Coroner and The Coroners' Society of England and Wales (2016)
<www.cps.gov.uk>publication>agreement-between-cr…>accessed 13 May 2020

Crown Prosecution Service,

Police: Guidance on the Handling of Allegations of Criminal Offences against the Police (16 August 2018) <www.cps.gov.uklegal-guidance>police-guidance-handling> Accessed 20 May 2020

Crown Prosecution Service

Code for Crown Prosecutors 8th Edition, October 2018 <www.cps.gov.uk/publication/code-crown-prosecutors> accessed 13 May 2020

Chief Coroner,

Guidance No.22. Pre-Inquest Review Hearings <www.judiciary.uk.wp-content>uploads>2013/09>guidance-no22> accessed 13 May 2020

Chief Coroner,

Law Sheet No. 1: Unlawful killing <www,judiciary.uk>wp-content>uploads>2016/02>accessed 20 October 2020

Chief Coroner,

Fifth Annual Report: 2017–2018, Annexe C. <www.gov.uk/government/publications> accessed 14 May 2020.

Cutler Keith,

Inquest Into the Death of Mark Duggan - Report to Prevent Future Deaths (HM Coroner for North London, 2014) <www.judiciary.uk>2014/06>Duggan-2014-0182> accessed 24 May 2020

Department for Constitutional Affairs

Reform of the Coroners' System and Death Certification: Government Response to the Constitutional Affairs Select Committee's Report (HC 6943, 2006)

Department for Constitutional Affairs

Coroner Reform: The Government's Draft Bill : Improving Death Investigation in England and Wales (CM 6849, 2006)

Department of the Environment, Transport and the Regions,

Public Inquiry into the Identification of Victims Following Major Transport Accidents (Cm 5012, 2001)

Department of Health,

The Royal Liverpool Children's Inquiry Report (HC 12-11, 2001)

Essex County Council,

The Coroner Service: Council's Corporate and Customer Services <coroner.essex.gov.uk> accessed 17 May 2020

Equality and Human Rights Commission,
Human Rights Inquiry: Report of the Equality and Human Rights Commission (Equality and Human Rights Commission, June 2009)

European Court of Human Rights
Guide on Article 2 of the European Convention on Human Rights: Right to life (updated 31 August 2020) <www.echr.coe.int › Documents> Guide_Art_2>ENG >accessed 7 September 2020.

European Court of Human Rights,
Guide on Article 6 of the European Convention on Human Rights - Right to a Fair Trial (Criminal Limb) (European Court of Human Rights, 2020)

Fairbairns C and Lairds JS,
Inquests and Public Inquiries (HC Briefing Paper No 08012, 21 June 2017)

HM Coroner,
'The London Bridge Attack' London Bridge Inquests, <www.londonbridgeinquests.independent.gov.uk/inquests> accessed 24 May 2020

Home Office.
The Anthony Grainger Inquiry: Report into the Death of Anthony Grainger (HC 2354, 2019)

House of Commons Home Affairs Committee,
Inquiry into police conduct and complaints, 28 October 2019 <www.parliament.uk> business>news>parliament-2017> accessed 8 September 2020

Home Office,
Police use of firearms statistics <https://www.gov.uk> accessed 11 August 2020

Home Department,
The Brixton Disorders, April 10-12 1981: *Report of an Inquiry* (Cm 8427, 1981)

Home Department,
The Shipman Inquiry (2004) 3rd Report Third Report Death Certification and the Investigation of Deaths by Coroners (Cm 5854, 2003)

Home Department,
Reforming the Coroner and Death Certification Service: A Position Paper (Cm 6184, 2004)

Home Office,
Committee on Death Certification and Coroners (Brodrick Report): Minutes and Papers (HO 375, 1971)
Home Office,
HO Circular 20/1999

Home Office,
The Stephen Lawrence Inquiry Report (Cm 4262–1, 1999)

Home Office,
Deaths in Police Custody: Guidance (Home Office Circular 31/2002

Home Office,
Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review (Cm 5831, 2003)

Home Office,
Report of the Hillsborough Independent Panel: Hillsborough (HC 581, 2012)

Home Office,
Triennial Review of the Independent Police Complaints Commission (2015)

Home Office,
Report of the Independent Review of Deaths and Serious Incidents in Police Custody (HO 2017)

Home Office,
The Anthony Grainger Inquiry: Report into the Death of Anthony Grainger (HC 2354, 11 July 2019)

Home Office,
Government's Response to Anthony Grainger public inquiry (May 2020)

IOPC,
Consultation response: Legal representation for families at inquests (IOPC, August 2018)

IPCC,
Review of the IPCC's work in investigating deaths; Final Report (IPCC, March 2014)

Joint Committee on Human Rights
The Human Rights Act: the DCA and Home Office Reviews Thirty–second Report of Session 2005–06 (HL Paper 278 HC 1716)

London Borough of Hammersmith and Fulham,
Coroners and mortuary <www.lbhf.gov.uk › births-deaths-and-marriages › deaths > accessed 17 May 2020.

Ministry of Justice,
Implementing the coroner reforms in Part 1 of the Coroners and Justice Act 2009: Consultation on rules, regulations, coroner areas and statutory guidance (CP2/2013, 4)

Ministry of Justice,
Final report: Review of legal aid for inquests (CP 39, 2019)

Ministry of Justice,
Lord Chancellor's Exceptional Funding Guidance (Inquests) (August 2015 updated April 2020)

NHS Management Executive,
The Allitt Inquiry: Independent Inquiry Relating to Deaths and Injuries on the Children's Ward at Grantham And Kesteven General Hospital during the Period February to April 1991 (HMSO 1994)

Office of the Chief Coroner
Report of the Chief Coroner to the Lord Chancellor: First Annual Report 2013-2014 (HMSO 2014)

Operational Selection Policy OSP6
Records created by and relating to Coroners 1970–2000, para 3.5 (The National Archive amended May 2007)

Police Complaints Authority,
Review of shootings by police in England and Wales from 1998 to 2001 (HC 313, 2003)

Smith J,
The Shipman Inquiry: Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future (Cm 6394-I/II/III, 2004)

Wright Robert A,
Report of the Departmental Committee on Coroners (Cm 5070, 1936)

JOURNAL ARTICLES

'The Coroners and Crime' (1939) 3(2) The Journal of Criminal Law 3 304

Aberdeen J,

‘Blowed off by a Side Wind? Coronial Inquests Following Criminal Acquittals’ (2016) 23 Journal of Law and Medicine 491

Baker D,
‘Researching Deaths after Police Contact: Challenges and Solutions’ (2016) 2(1) Journal of Criminological Research, Policy and Practice 15

Baker D,
‘Deaths after Police Contact in England and Wales: The Effects of Article 2 of the European Convention on Human Rights on Coronial Practice’ (2016) 12 International Journal of Law in Context 162

Baker D,
‘‘These people are vulnerable, they aren’t criminals: mental health, the use of force and deaths after police contact in England’ (2019) 93 (1) Police Journal: Theory Practice and Principles 65

Baker D, Norris D and Cherneva V,
‘Disenfranchised Grief and Families’ Experiences of Death After Police Contact in the United States’ (2020) OMEGA - Journal of Death and Dying 1

Baker D and Pillinger C,
‘”These People Are Vulnerable, They Aren’t Criminals”: Mental Health, the Use of Force and Deaths after Police Contact in England’ (2020) 93 The Police Journal: Theory, Practice and Principles 65

Beckett C,
‘Deaths in Custody and the Inquest System’ (1999) 19 Critical Social Policy 271

Beckley A,
‘Judicial Review — How the Police Are Helping with Their Own Inquiries: Part Three: Police Procedures and Operations’ (1997) 70 The Police Journal: Theory, Practice and Principles 237

Bray S,
‘Coronial Law Reform’ (2010) 35 Alternative Law Journal 232

Bray S and Martin G,
‘Frontiers in Coronial Justice – ushering in a new era of coronial research’ (2016) 12(2) International Journal of Law in Context 103

Burton J,
‘Is There Any Future for Inquests and Inquiries?’ (1999) 67 Medico-Legal Journal 91

Chevalier-Watts J,

‘Effective Investigations under Article 2 of the European Convention on Human Rights: Securing the Right to Life or an Onerous Burden on a State?’ (2010) 21 European Journal of International Law 701

Coles D and Shaw H,
‘Deaths in Custody — Truth, Justice, and Accountability? The Work of INQUEST’ (2006) 33(4) Social Justice 136

Darley JM and Pittman TS,
‘The Psychology of Compensatory and Retributive Justice’ (2003) 7 Personality and Social Psychology Review 324

Donald A,
‘Evaluating the Impact of Human Rights Litigation on Policy and Practice: A Case Study of the UK’ (2009) Journal of Human Rights Practice 339

Freckelton I,
‘Death investigation, the coroner and therapeutic jurisprudence’ (2007) 15 JLM 1

Freckleton I,
‘Reforming Coronership: International Perspectives and Contemporary Developments’ (2008) 16 JLM 379

Freckelton I,
‘Minimising The Counter-Therapeutic Effects Of Coronial Investigations: In Search Of Balance’ (2016) 16 QUT Law Review 4

Hanzlick R,
‘The Conversion of Coroner Systems to Medical Examiner Systems in the United States: A Lull in the Action’ (2007) 28 The American Journal of Forensic Medicine and Pathology 279

King M,
‘Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model’ 16 (2008) JLM 442

Luce T,
‘Death Certification and the Coroner Service’ (2004) 44 Medicine, Science and the Law 287

Martin G and Bray RS,
‘Discolouring Democracy? Policing, Sensitive Evidence, and Contentious Deaths in the United Kingdom’ (2013) 40 Journal of Law and Society 624

McIntosh S,
‘Fulfilling Their Purpose: Inquests, Article 2 and next of Kin’ (2012) 3 Public Law 407

McIntosh S,
‘Taken Lives Matter: Open Justice and Recognition in Inquests into Deaths at the Hands of the State’ (2016) 12 International Journal of Law in Context 141

Mclaughlin E and Murji K,
‘Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model’ 16 (2008) JLM 442

MacMahon P,
‘The Inquest and the Virtues of Soft Adjudication’ (2015) 33 Yale L. & Pol’y Rev 275

Prictor M,
The Sideshow or the Circus? The Role for Public Interest Organisations at Inquests’ (2012) 20 JLM 320

Rogers MD,
‘Police Force! An Examination of the Use of Force, Firearms and Less-Lethal Weapons by British Police’ (2003) 76 The Police Journal: Theory, Practice and Principles 189

Savage SP,
‘Thinking Independence: Calling the Police to Account through the Independent Investigation of Police Complaints’ (2013) 53 British Journal of Criminology 94

Smith J,
‘The Shipman Inquiry – Death Certification’ (2004) 44(4) Medicine, Science and the Law 280-287

Tait G and Carpenter B,
‘Suicide and the Therapeutic Coroner: Inquests, Governance and the Grieving Family’ (2013) 2 International Journal for Crime, Justice and Social Democracy 92

The Lancet,
‘Report on Coroners’ (1936) 227 (Issue 5868) The Lancet 377

Upjohn G,
‘Evolution of the English Legal System’ [1965] 51 ABA Journal 918-921.

Waters I,
‘Police Complaints and the Complainants’ Experience’ (2000) 40 British

Journal of Criminology 617

Waters I and Brown K,
‘Police Complaints’ Experience’ (2000) 40 The British Journal of Criminology 617

Weissbrodt DS,
The Right to a Fair Trial under the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights (2001)

Wells C,
‘Inquests, Inquiries and Indictments: The Official Reception of Death by Disaster’ (1991) 11 Legal Studies 71

Winick BJ,
‘The Jurisprudence of Therapeutic Jurisprudence’ (1997) 3 Psychology, Public Policy and Law 184

OTHER PRINT SOURCES

Burrows C,
A Review of the Discharge of Firearms by Police in England and Wales 19911993 Joint Standing Committee on the Police Use of Firearms in consultation with the PCA (unpublished)

Committee on the Administration of Justice,
Inquests-Disputed Killings in Northern Ireland (CAJ 1992) (pamphlet)

Committee on the Administration of Justice,
‘Memorandum to the Joint Committee on Human Rights’ (2003)

Department for Constitutional Affairs,
A Guide to the Human Rights Act 1998: Third Edition (October 2006)

Guide on Article 2 of the European Convention on Human Rights. Right to Life European Court on Human Rights. Updated 30 April 2020.
<www.echr.coe.int>Documents>Guide_Art_2>ENG>accessed 12 May 2020.

INQUEST,
The inquest handbook: A guide for bereaved families, friends and advisors (INQUEST 2016) (pamphlet)

Morgan R and Evans M,
Combating Torture in Europe: The Work and Standards of the European

Committee for the Prevention of Torture'(CPT) (Council of Europe Publishing 2001)

Thomas C,
Are Juries Fair? (Ministry of Justice Research Series 1/10, 2010)

INTERNET SOURCES

An Phoblacht (Online) Edition,
'O'Neill inquest disgrace, Coroner warns jury not to make a ``martyr'' ' (24 February 2000) <https://www.anphoblacht.com/contents/5913> accessed 20 May 2020

Anna Savva,
'Lawful killing' verdict returned in inquest into county's first fatal policeshooting' (Cambridgeshire News, 21 July 2017) <www.cambridgeshirenews.co.ukNews>Cambridgeshire.News> accessed 24 May 2020.

BBC News,
'Siege man was lawfully killed' (BBC news online, 12 April 2002) <www.bbc.co.ukuk_news>england> accessed 10 October 2020.

BBC News,
'Police justified in killing former soldier' (BBC news online, 2 May 2002) <www.bbc.co.uk_news>england> accessed 25 May 2020.

BBC News,
'Lawful killing after police shoot man (BBC news online, 8 November 2002) www.bbc.co.uk>uk_news>england> accessed 26 May 2020

BBC News,
'Gunlighter man lawfully killed' (15 December 2004) <news.bbc.uk_news>england>london> accessed 2 August 2020

BBC News,
'Armed man's killing was lawful,' (BBC news, 8 March 2005) <news.bbc.co.uk>_news>beds>bucks>herts> accessed 26 May 2020. See also www.pressgazette.co.uk_- editor-beats-id-> accessed 26 May 2020.

BBC News,
'Dealer shooting "lawful killing"' (BBC news, 25 November 2005) <news.bbc.co.uk _news>england>bristol>somerset> accessed 28 May 2020.

BBC News,

'Swordman's shooting was "lawful"' (BBC news, 11 November 2005) <news.bbc.co.uk >uk_news>england>cornwall> accessed 27 May 2020

BBC News,
'Gunman lawfully killed by police' (BBC news, 27 July 2005) <accessed on 28 May 2020

BBC News,
'Kent robbery suspect "lawfully killed"' (BBC news, 25 January 2010) <www.bbc.co.uk_newsengland>kent> accessed 20 May 2020.

BBC News,
'Replica Uzi gun man "lawfully killed" by Kent Police'
(BBC news 1 March 2010). <www..bbc.co.uk>uk_news>england>kent> accessed 28 May 2020.

BBC News,
'Woman shot dead by police "lawfully killed" jury rules' (BBC news, 29 April 2010) <news.bbc.co.uk>uk_news>England>kent> accessed 29 May 2020.

BBC News,
'Chief Coroner: Royal British Legion welcomes U-turn' (BBC news 23 November 2011} <www.bbc.co.uknews>uk-politics-15859410> accessed 20 December 2020.

BBC News,
'Michael Fitzpatrick inquest' (BBC news 3 February 2012) <www.bbc.co.uknews>uk_england_sussex-16875737> accessed 28 May 2020

BBC News,
'Police blamed over 1985 Cherry Groce Brixton shooting' (BBC news, 10 July 2014) <www.bbc.co.uknews>uk-england-london-28248588> accessed 10 October 2020

BBC News,
'Mark Duggan death: Timeline of events' (BBC news, 27 October 2015) <www.bbc.co.uk>news>uk-england-london-148424> accessed 10 October 2020

BBC News,
'James Fox father "disappointed" with lawful killing ruling' (BBC news online ,23 September 2016) <www.bbc.co.uk-england-london-37455703> accessed 24 May 2020

BBC news,

‘Josh Pitt: knifeman shot by police gunman lawfully killed’ (BBC online news, 14 January 2019) < www.bbc.co.uk>news>uk-englad-beds-bucks-herts-> accessed 24 May 2020

Bhatt Murphy Solicitors, INQUEST and Liberty,

‘Response to consultation paper on Attorney General’s review of the role and practises of the CPS in cases of deaths in custody’ (June 2002)

Bindmans Solicitors,

‘Anonymity for firearms officers refused in the Dean Joseph inquest’ <www.bindmans.comnews>anonymity-for-mps-fireatms. . .> accessed 11 September 2020.

Black Lives Matter,

< blacklivesmatter.com> accessed 13 May 2020

British Sussex County Police,

‘The killing of James Asley’ (undated) <www.mojuk.org.ukPortia>ashley> accessed 18 May 2020

Chris Fay,

‘Inquest finds Shildon crossbow man “deliberately provoked” police marksmen’ (Northern Echo, 7 November 2011) <www.thenorthernecho.co.uk › news › 9348602.inquest... > accessed 29 October 2020

Clare Margetson,

‘IRA suspect killed lawfully, inquest rules (The Guardian 18 February 2000) http://www.theguardian.com/uk/2000/feb/18/northernireland..cla accessed 10 August 2020

Conor Shine,

‘Commission shelves coroner’s inquests for new “police fatality review process”’ (Las Vegas Sun, 7 January 2013).<lasvegassun.com>news>2013>jan>07>commission> accessed 20 May 2020.

David Waddington,

‘The law of moments: understanding the flash point that ignited the riots’ (cjm 87, March 2012) <www.crimeandjustice.org.ukcjm>article>lawmom...> accessed 23 July 2020

Douglas Quan,

‘Dying to be heard: Expert views on how to resuscitate our inquest system’ (17 January 2014).

Ellena Cruse,

‘Man shot dead by police posed “immediate threat to life” after firing air pistol, report finds’ Evening Standard (UK, 17 March 2020) www.standard.co.uk news > UK>. Accessed 20 October 2020

Emma Youle,
‘Dean Joseph inquest: ‘Met Police “regrets” killing of Islington man in hostage siege’ (Islington Gazette, 13 August 2015)
<www.islingtongazette.co.uk › news › crime-court › dea...> accessed 20 October 2020

Gareth Parry, Susan Tirbutt and David Rose,
‘From the archive: Riots in Brixton after police shooting,’ originally published The Guardian (30 September1985)<www.the guardian.com>the guardian>Sep>brixton-ri…> accessed 20 October 2020

Independent,
‘Wall of silence from white youths at Lawrence Inquest’ (Independent 12 Feb 1997) <www.independent.co.uknews>wall-silence-from> accessed 13 May 2020

INQUEST,
<www.inquest.org.uk> accessed 20 October 2020

INQUEST,
‘How the inquest system fails bereaved people: INQUEST’s response to the fundamental review of coroner services’ (2002)
<www.scribd.com › document › How-the-Inquest-Syste...> accessed 20 October 2020

INQUEST,
INQUEST Lawyers Group/Police Actions Lawyers Group Briefing (March 2006) < www.palg.org.uk>app>download>Fatal+shootings+. . .> accessed 9 August 2020

INQUEST,
‘Briefing on Coronial Reform’ (March 2011)
<iap_deathsincustody.independent.gov.uk>2011/08>IN>accessed 12 May 2020

INQUEST,
‘Jury’s verdict of unlawful killing at inquest into the death of Ian Tomlinson vindicates family and public concern.’ (3rd May 2011) <www.inquest.org.uk>ian-tomlinson-inquest-conclusion> accessed 10 September 2020.

INQUEST-Liberty-Justice,

‘Joint Briefing on Clauses 11–13 of the Coroners & Justice Bill for the Report Stage in the House of Commons, 29 para 44. <justice.org.uk>wpcontent>uploads>2015/03>Cor..> accessed 13 May 2020

INQUEST,
‘Inquest into the fatal shooting of James Fox by Metropolitan Officers concluded’ (23 September 2016) <www.inquest.org.ukjames-fox-inquestclosing> accessed 11 September 2020.

INQUEST,
‘Inquest concludes fatal shooting of Josh Pitt by Bedfordshire police was ‘lawful killing’ (14 January 2018)<www.inquest.org.ukinquest-concludesfatal-shooting> accessed 11 September 2020

INQUEST,
‘Enforcing Human Rights’ - written evidence from INQUEST to House of Commons Joint Committee on Human Rights, (2018, AET0038) <publications>parliament>jtselect>jrights> accessed 16 May 2020

INQUEST,
‘INQUEST’s response to the Ministry of Justice consultation on establishing an Independent Public Advocate (December 2018) <www.inquest.org.uk>accessed 13 May 2020.

INQUEST,
‘Now or never. Legal aid for inquests’ (26 February 2019) <www.inquest.org.uk>legal- aid-for-inquests> accessed 18 May 2020

INQUEST,
‘High court quash coroner’s anonymity ruling and allows family of Andrew Hall to see inquest evidence of police officers ‘(INQUEST, 7 November 2019)< www.inquest.org.uk › high-court-quash-coroners-anon.... >accessed 20 October 2020

INQUEST,
‘Fatal Police Shootings (England & Wales) 1990-date. <www.inquest.org.uk › fatal-police-shootings> accessed 20 September 2020

INQUEST:
‘Statistics and monitoring’(updated 22 October 2020) <www.inquest.org.uk>pages>categories>statistics-and-> accessed 10 May 2018 and 20 October 2020

James Sturcke,
‘Met police guilty over De Menezes shooting’ (The Guardian, 1 November 2007) <www.theguardian.com>nov>menezes.jamessturcke2> accessed 18 May 2020

Jason Bennetto,

‘Police officer cleared of murder’ (Independent 15 October 1997) www.indepedent.co.uk.new>police-officer-cleared> accessed 18 May 2020

Jonathon Rogers,

‘“Lawful killing” conclusions in inquests are misleading’ (UCL, 2014) www.ucl.ac.uknews>’sep>lawful-killing’-con.. . .> accessed 6 June 2020.

Josh Loeb,

’Police shooting prosecutions: No law change needed by investigations but must be speedier’ (Police Oracle 15 July 2015)
www.policeoracle.comnews>2015>July>15>police< accessed 16 May 2020

Keith Lee,

‘Britain: Open verdict on man shot by police’ (World Socialist Website, 1 July 2002)<www.wsws.org>articles>2002/07>stan-j01> accessed 28 May 2020

Kevin McCloughlin,

Lexis Nexis, Practice Note: Procedure at coroners’ inquests. www.lexisnexis.co.uklegal>procedure-at-coroners-inquest> accessed 22 May 2020

Koos Covee,

Deaths in British police custody: no convicted officers since 1969
<www.opendemocracy.netopensecurity>death-in-british> accessed 17 May 2020

Louise Cooper,

‘Police marksman's shots were justified' - jury record narrative verdict in Alistair Bell inquest, (ExaminerLive Yorkshire, 29 January 2014)
<www.examinerlive.co.uk>News>AlistairBell>accessed 24 May 2020

Mailonline,

‘Police “justified” in shooting charity worker inquest reveals’ (Mailonline, 2 April 2008) <www.dalymail.co.uknews>article-554388>Police-> accessed 26 May 2020

Mark Tran, James Strucke and agencies,

‘De Menezes family criticise inquest as a ‘whitewash’ ‘(The Guardian, 12 December 2008) www.the guardian.com>dec>de-menezes-family-critic…> accessed 9 August 2020.

Martin Shaw,

‘”The battle begins now" says Yassar Yaqub's dad as police probe ends’ (ExaminerLive, 31 December 2018) < *www.*examinerlive.co.uk/news/thebattle-begins-now-says-17493078 > accessed 20 October 2020

Mark Tran, James Strucke and agencies,
‘De Menezes family criticise inquest as a ‘whitewash’ ‘(The Guardian, 12 December 2008) www.the guardian.com>dec>de-menezes-family-critic…> accessed 9 August 2020

Mike Carter,
‘King County reinstates police deadly-force inquests following overhaul’ Seattle Times 30 May 2019. http://www.seatletimes.com>accessed 20 May 2020.

News Shopper,
‘”Suicide by cop” verdict condemned’ <www.newsshopper.co.uknews>6247813.suicide-by-.. . .> accessed 13 July 2020

News Shopper,
15 May 2003 <www.newsshopper.co.uknews>6247813.suicide-by-> accessed 25 May 2020

Owen Bowcott,
‘Jean Charles de Menezes: family lose fight for police officers to be prosecuted’ *The Guardian* (30 March 2016*)* www.the guardian.com>uknews>marc>jean-charles..> accessed 9 August 2020.

Peter Walker and Paul Lewis,
‘Ian Tomlinson death: Simon Harewood cleared of manslaughter’ (The Guardian 19 July 2012) www.the guardian.uk>jul>simon-harewood-notguilty-i..> accessed 10 September 2020

Police Professional,
‘Family loses case against MPS over son who was shot dead by officer’<www.policeprofessonal.comnew>family-loses-case> accessed 11 September 2020.

Rebecca Allison,
‘UK’s first “suicide by cop” ruling’ (The Guardian, 10 May 2003) <www.theguardian.com>may>UKcrime.ukguns> accessed 30 July 2020

Richard Edwards,
‘Jean Charles de Menezes inquest: Family protest as jury sent out to consider verdict’ (The Telegraph,4 December 2008)

<www.telegrah.co.uknews>JeanCharlesde-Menezes-i> accessed 28 May 2020.

Richard Edwards and Gordon Rayner,
‘Jean Charles de Menezes inquest: Jury returns open verdict’ (The Telegraph, 12 December 2008) <www.telegraph.co.uknews>uknews>law-and-order> accessed 28 May 2020.

Rights NI,
‘Inquests into Controversial Deaths in Northern Ireland Delayed, Again’ (Rights NI, 2012) <http://rightsni.org/2012/11/inquests-into-controversialdeaths-in-northern-ireland-delayed-again/> accessed 20 October 2020

Sam Jones,
‘Mark Saunders was killed lawfully, inquest jury finds’ (The Guardian, 7 Oct 2010) <www.the guardian.com>oct>mark-saunders-inquest> accessed 27 May 2020

Sonia Sharma and Kathryn Riddell,
‘Police shooting inquest: Updates from three-week hearing and verdict on James Carlo Wilson's death’ (ChronicleLive South Shields, 27 November 2018) <www.chroniclelive.co.ukSouth Shields> accessed 24 May 2020

The Argus,
‘Inquest into Brighton police shooting death’ (The Argus*,* 27 January 2012) <www.theargus.uk.news-94980007.inquest-intr-bri accessed 28 May 2020

The Guardian,
‘Killing of man with table leg ‘unlawful’ (The Guardian, 29 October 2004) <www.theguardian.com>oct>ukcrime1> accessed 28 May 2020

The Guardian,
‘Mark Duggan shooting: family settle high court claim against Met’ (The Guardian, 10 Oct 2019) <www.theguardian.com>iuk-news>oct>markduggan> accessed 12 May 2020

The Journal,
‘Stocksfield shooting inquest verdict’ (The Journal, 13 December 2007) <www.thejournal.co.uk>News>North East News> accessed 27 May 2020

The Murden family,
‘Response to the DPP statement following the inquest, April 2008, Simon Murden – Africa Lands Trust <www.fricalandstrust.co.uksimon> accessed 10 August 2020

The Telegraph,
‘De Menezes inquest: Jury reaches open verdict’ (The Telegraph, 12 December 2008) www.telegraph.co.uknews>uknews.law-and order> accessed 29 May 2020

The Telegraph,
‘Man shot by police outside Guildford Cathedral “lawfully killed”’ (The Telegraph, 21 August 2009)
<www.the telegraph.co.uk>news>uk_news>law-and-order> accessed 25 May 2020

Tony F Marshal,
‘Restorative Justice: An Overview’(1999) Home Office Research, Development and Statistics Directorate (occasional paper, cjm 87) <www.crimeadjustice.org.uksites>files>0962751>accessed 20 October 2020

UK Parliament,
‘Establishing a public inquiry into the death of Jermaine Baker’ (HLWS104, February2020)<www.parliament.ukpublications>Lords>HLWS104> accessed 24 May 2020

Victoria Rosenberg,
‘Police give gunman his suicide wish’ (The Times, 8 January 2004) <*www.thetimes.co.uk* › article › police-gave-gunman-his-s.> accessed 20 October 2020

Walen, Alec,
‘Retributive Justice’ The Stanford Encyclopaedia of Philosophy *(Fall* 2020 Edition), Edward N. Zalta (ed.),
URL<https://plato.stanford.edu/archives/fall2020/entries/justice-retributive/ <accessed 20 October 2020

4WardEver,
‘Lawful killing verdict returned by inquest jury’ (4WardEver, 10 January 2005) <4wardever.org>cases>adult-cases-uk>shootings> accessed 24 May 2020