# Inquests and Inquiries following medical disasters and the use of force by the police

**Dijen Basu QC**

## DEATHS RESULTING FROM THE USE OF FORCE BY THE POLICE

### Inquest or public inquiry?

Where deaths occur in custody or as a result of the use of force by police officers, the families of the deceased, whose views are deserving of the highest respect, usually prefer an inquest because (1) they are usually speedier, (2) there will usually be a jury, (3) a strong conclusion of unlawful killing is *potentially* available and (4) they are entitled to ask questions of witnesses as of right.

Sometimes it is simply not possible for a coroner to investigate the death because potentially material evidence is of a type which has to be considered by a judge. Sometimes the problem will be cured by having a judge sit as coroner. That cure will be less effective the more relevant the problem is to the statutory questions, particularly to the wider "*in what circumstances*" questions at the heart of a ***Middleton*** inquest. The problem is even more acute if a jury is to sit. Example of cases where an inquest has not been possible is the Azelle Rodney Inquiry, referred to below, and the Litvinenko inquiry. Only Parliament could change this state of affairs, but there appears to be no appetite so to do.

So-called **public interest immunity**[1] is one particular problem. The police may be under a duty to withhold certain documents in the public interest which are relevant to the statutory questions in an inquest or to the terms of reference of a public inquiry. The statutory design of the Coronial jurisdiction is, by its very design, often ill-equipped for this situation. In civil or criminal litigation, justice can be achieved by resetting the balance between the parties or, sometimes, by a closed material procedure. But the existence of material which is relevant and material to one of the statutory questions may well render an inquest impossible. In essence, this was the problem that prevented Sir Robert Owen

[1] a misnomer – but a convenient way of describing the situation where documents may not be inspected (indeed, sometimes even their very existence cannot be disclosed) because to do so would cause such harm to the public interest as outweighs the interests of open justice

(a former High Court Judge) sitting as a coroner in the inquest into the death of Alexander Litvinenko. Instead, a public inquiry was necessary and he sat as its chairman.

At §44 of his judgment in ***Secretary of State for the Home Department v HM Senior Coroner for Surrey & ors*** [2016] EWHC 3001 (Admin), Cranston J explained this particular difficulty:-

"A more difficult issue of sensitivity arises where the problem is with disclosing sensitive material to the coroner himself. Statute prevents disclosure to coroners of intercept material obtained under the Regulation of Investigatory Powers Act 2000 ("RIPA") … . In broad terms, section 17 of RIPA prohibits evidence, questioning or assertion in connection with legal proceedings likely to reveal a communications intercept. Section 18(7)(b) excludes from the prohibition disclosure to a relevant judge in a case in which that judge has ordered the disclosure to be made to him alone. Also excluded from the prohibition is a panel conducting a statutory inquiry under the Inquiries Act 2005: s. 18(7)(c). For our purposes, the interest is that "relevant judge" is defined in section 18(11) as:

"(a) any judge of the High Court or of the Crown Court or any Circuit judge;

…

(d) any person holding any such judicial office as entitles him to exercise the jurisdiction of a judge falling within paragraph (a)…""

The greater procedural and substantive armoury of a public inquiry, while often undesirable to families, may be the only tenable means of discharging the State's obligation to investigate the death.

<u>Police use of firearms</u>

The majority of officers in United Kingdom police forces are <u>not</u> routinely armed. Exceptions are members of the Police Service of Northern Ireland and of the Civil Nuclear Constabulary (a Great Britain wide police force).

Police officers very rarely open fire on people in the UK. Every use of a police firearm by a British police officer is newsworthy and each one that causes **death or serious injury** must be reported by the force to the Independent Police Complaints Commission.

When a police officer opens fire on a person, s/he is an agent of the State who intentionally uses deadly force which can only be justified by the police where it is **absolutely necessary** (see ***McCann v UK*** (1996) 21 EHRR 97, §§148 – 149). Not only should that officer's actions be examined "*but also all the surrounding circumstances including such matters as the planning and control of the actions under examination*" (***McCann*** §150). That will be the task of the inquest or inquiry into the death.

If an officer fires on a person in the course of his or her duties, then he or she will usually have the *Mens Rea* for murder should death ensue (but usually not for attempted murder should death not ensue, because firearms officers usually do not 'shoot to kill', whatever ill-informed politicians or journalists may say). If the officer does so without genuinely believing that that was necessary in self-defence or for the defence of another), then s/he will have no defence to a charge of murder (or of inflicting GBH if the person survives).

Deployment of armed officers

The deployment of armed police officers may only be authorised where one or more of the following circumstances pertains:-

1. where there is reason to suppose that officers may have to protect themselves or others from a person who:

   (a) **is in possession of, or has immediate access to, a firearm or other potentially lethal weapon**, or

   (b) **is otherwise so dangerous** that the deployment of armed officers is considered to be appropriate, or

2. because the threat assessment carried out for a particular operation requires the carrying of firearms as an **operational contingency**, or

3. for the destruction of **animals** which are dangerous or are suffering unnecessarily.

In an inquest or inquiry following a fatal police shooting, it will be important to examine the recorded justification for the deployment of armed police.

This is because it is always important to consider whether the threat perceived by the officer could have been met with a less lethal option, e.g. a taser, had that option been available to that officer or another officer nearby. It is possible that an officer under (perceived) attack, would adequately have been able to meet the threat by the use of a taser to incapacitate the attacker but reacted by using his/her firearm because no taser was to hand.

Whether in the planning or assessment phase of an operation, the operational briefing, the execution phase or at the point in time where an officer feels under threat, consideration should if possible be given to the use of '**less lethal options**' – e.g. taser, CS Spray, batons, dogs etc.

Types of deployment

As is obvious, armed police officers are often deployed **overtly**, e.g. in the vicinity of potential terrorist targets, such as prominent buildings and railway stations.

They are also deployed **covertly**, breaking cover only if an armed interception becomes necessary. Officers carrying out **surveillance** may be armed, if the criteria for arming are met. They may need firearms for their own protection, for example, should they become compromised.

Armed officers may provide 'mobile armed support to surveillance' (or **MASTS**), on foot or in vehicles. It is possible that such a deployment will end in an armed interception. An example is the enforced vehicle stop which ended in the shooting dead of Azelle Rodney. This has become known as a 'hard stop', although not by police.

Armed officers may also covertly be deployed to counter a significant **threat to life**. Disrupting the criminal activities believed to be in progress carries a real risk of the need to draw firearms.

Command structure

The 'GSB' structure is typically used.

The **Gold** (Strategic) Commander is a very senior officer who sets the overall strategy. He or she may well be the officer who authorises the armed deployment.

The **Silver** (Tactical) Commander is the senior officer who is in charge of the tactics during the operation, including as it evolves, putting Gold's strategy into effect and coordinating the information coming in from the Bronze Commander(s), from intelligence officers liaising with other organisations and from surveillance officers. The Silver Commander may have one or more **tactical advisers**.

The **Bronze** (Operational) Commander(s) is/are the officer(s) on the ground, much closer to the events. The bigger the operation, the more Bronze Commanders there are, each with a particular remit.

Typically, commanders will have scribes who maintain a contemporaneous **decision log** recording the decisions taken and the rationale for them, including noting the intelligence picture as it changes. Those decision logs will greatly later assist in understanding how the operation unfolded and why decisions were taken.

If the matter arises out of what is considered to be a **critical incident**, a **Gold Group** may be formed. It will usually be chaired by Gold and will often include input from operational staff, intelligence officers, those who liaise with other agencies and lawyers. These meetings are usually minuted and they may be relevant to the investigation of the ensuing death. Questions of litigation privilege or legal advice privilege may arise.

Pre-deployment briefing

These briefings are sometimes tape-recorded, given their significance. The contents of the briefing will be important. Were officers given accurate and adequate information with the risks fairly set out? Were material errors made which made the deceased wrongly appear more dangerous or which confused him/her with someone else?

Sources of information to the police

Intelligence about the subject of an armed operation may come from a number of different places and its timing will be important. What did the police know and when did they know it? How, and to whom, was the information disseminated? It will be important to know what information was available to commanders when they finally settled upon their plan to intercept their suspects.

The last piece in the puzzle will be the question what was known to the officer(s) who fired the relevant shot(s).

Where intelligence originates (or is 'owned by') external agencies, police may well only ever know a gist of the information (perhaps not even its source) and its grading – in terms of the reliability of the source of the information and the source's confidence in that information.

Intelligence ranges from being highly relevant and compelling to being downright misleading or untrue.

The **intelligence picture** is exactly that. Like any other picture, it is made up of multiple smaller components. Individually, those components may not tell you much. In fact, some of them may be inaccurate, misleading or untrue. Those taking important decisions will need to accumulate the intelligence picture, assess it and then decide upon next steps.

Testing police decision making at any giving point in the operation must be done having regard to a snapshot of the intelligence picture at that point. The confidence that a suspect is armed may go down and up a number of times, as intelligence is received. PII will be an obvious consideration, with the police reluctant to reveal sources, methods and coverage.

Decision making

One of the key questions in a pre-planned (as opposed to reactive) operation is how and why the decision where, when and how to intercept the suspects was made. If there is intelligence as to where the suspects are going and why then police will be able to seek to plan to intercept them in a location and by means which involved the lowest risk and the greatest control. If suspects are being followed on their way from north London to commit an armed robbery on Bond Street, it may be safer and easier to stop them after they have collected their weapons but before they reach the busier streets of central London. It may be better still to intervene at the point of handover of the weapons, if that is in a suitable location.

If those directing the operation wait until the suspects are at their most dangerous (a situation which has echoes of the facts of *McCann v UK*), then they may be criticised for allowing the need to use lethal force to increase to an unacceptable level. To wait to catch suspected armed robbers red-handed may well mean that shots will need to be fired to

stop criminals who are brandishing weapons. There will likely be much less risk to police, public and the suspects if any intervention is carried out well before the suspects are ready to use their weapons.

Immediately before and after the shooting

Immediately before and after a police shooting, the scene and the situation are likely to be very chaotic and confused. Perfectly honest and genuine people who are doing their best to tell the truth may have very different recollections of what happened. Research has shown that members of the public witnessing the same event will often describe it very differently indeed. Although often of greater resilience than members of the public, police officers involved in an incident where someone is shot dead by police may be shocked and unaccustomed to what has happened. It is entirely possible that the officer who has fired the fatal shot(s) has never opened fire before outside a firing range. Equally, it is important to be vigilant to detect any possibility that an officer is giving an exculpatory, and potentially changing, account under the cover of such difficulties in recollection.

The increasing use of **body worn video** recording devices means that pure reliance on recollection is now less necessary. In the age of the smartphone, no-one is more than a few seconds away from a high-quality video camera and important evidence may well come from third parties.

It is of central importance to know what was in the mind of the officer who opened fire and why. Experience suggests that, despite the confidence of bereaved families in them, rather than in judges or in coroners sitting alone, juries are likely to be very swayed by the perspective of the officer who fired the fatal shot(s). They may find it harder to criticise that officer and rather easier to look critically at those, higher in the command chain, who are responsible for the planning and execution of the operation.

Post incident first aid care is usually not at issue but it should be examined.

Following the incident, the person who opened fired the should not discuss the matter with his or colleagues. Very often, officers will quickly start to write up their recollections, while they are fresh in their minds.

The general practice, that officers will not confer prior to recording their first account of an incident ending in the fatal use of force, followed criticism of police after the fatal shooting of Mark Saunders, a barrister who had discharged a firearm a number of times out of the window of his flat.

Many forces have a **Post Incident Manager**, whose job is to manage the aftermath. His or her observations and notes may be revealing.

Analysis of the last moments

The courts have discouraged attempts minutely to analyse the moments before and during the use of force, given that the context of the use of force. One example was ***E7 (An Officer of the Metropolitan Police) v Holland (Chairman of the Azelle Rodney Inquiry)*** [2014] EWHC 452 (Admin). The first shot was followed by the second 0.22 seconds later, the third after 0.24 seconds, the fourth after 0.22 seconds, the fifth after 0.22 seconds and the sixth 0.21 seconds later. There was then a pause of 0.72 seconds before the seventh shot, which was followed, 0.21 seconds later, by the final shot. The officer opened fire within 0.6 seconds of the officer's car coming to a sudden stop next to the car in which Mr. Rodney was travelling as a passenger. The Court criticised the Chairman's shot-by-shot analysis of E7's decision making.

In the end, the above criticism of Sir Christopher Holland came to nought because his vital fundamental finding that E7 did not have an honest belief that "*the passenger* [Azelle Rodney] *had picked the weapon up and was about to use it*", was not irrational. That (strong) finding is to be contrasted with the acquittal of E7 (Anthony Long) by a jury at the Central Criminal Court at his ensuing trial for murder.

Lastly: witnesses

While police witnesses may be thought to have a natural tendency to wish to try to justify a shooting, often the other witnesses involved also have a potential credibility problem as a result of their involvement in criminality. Truly independent witnesses of fact are often hard to come by.

## DEATHS IN A HOSPITAL SETTING

Deaths connected with hospitals occur in a myriad of different circumstances. A confused, unwell or physically limited patient may fall, including out of bed. A drug error may result in a catastrophic complication, a drug interaction (with another drug) or anaphylactic shock (essentially, an often catastrophic allergic, or 'hypersensitivity', reaction). An asthmatic may incorrectly be given a $\beta$-blocker which precipitates a fatal asthmatic attack. An operation may lead to sudden exsanguination or slower occult (hidden) and unrecognised bleeding, to infection or to a complication resulting from surgical damage to an important structure. A psychiatric patient, or a patient admitted for the acute treatment of self harm, may take his or her own life. A laboratory examination of a biopsy may fail to identify cancerous cells. A drunk patient's (apparent) aggression may mask a grave head injury. A serious, but eminently treatable, problem may go unrecognised (e.g. hypo- or hyper-glycaemia). A language barrier may cause something vital to be missed.

More difficult are the cases where the death is caused by less obvious and stark shortcomings in care. Such cases involve a need for lessons to be learnt in order to improve future care for others. They may be subtle and hard to uncover – especially without the assistance of an expert.

More sinister cases involve deliberate harm being inflicted by healthcare professionals or by others. They may be very hard to detect, save by analysis of clusters and patterns. A shocking, but real, subset of these cases is Munchausen syndrome by proxy, where a relative or caregiver gains attention by harming their charge. This can happen in the hospital setting, where equipment or infusions are deliberately tampered with.

Lastly, there are the terrible scandals of the recent past, e.g. Mid Staffs and the contaminated blood products disaster. Often, they are less about fine analysis of medical evidence but the factual examination of who knew what when.

### The medical picture

Like the 'intelligence picture' referred to in the police section above, the medical picture consists of numerous pieces of evidence (some of which may be spurious, artefactual or even the result of a mistake) which must be viewed as a whole when looking at a death which is potentially the result of a medical disaster.

All of the medical records may need to be examined as there may be relevant clues (e.g. a rash, betraying a later fatal penicillin allergy, in childhood). Those notes should include all GP records, hospital (including nursing etc.) records, laboratory results and imaging (e.g. x-ray, MRI, CT etc.). Imaging usually consists of the 'pictures' themselves as well as a report by a specialist, stating what the 'pictures' show. Clinicians should look at both, as there are many cases where something has been missed on first inspection.

Sometimes, allergy information is considered so important that it is written prominently on the front cover of a person's medical records which may later not be photocopied along with those records.

Correspondence may help to identify miscommunications between healthcare professionals.

**Drug charts** in hospital will be important as they reveal a drug error or the risk of one. Drug mix ups cause deaths. Typically, the mistake will be the wrong patient, the wrong drug (or combination of drugs) or the wrong dose. A drug may be wrongly prescribed, wrongly dispensed or wrongly administered.

Some drugs, such as heparin, which is an anti-clotting agent, comes in very different **concentrations**, one preparation of which is 5 times more concentrated than the other. A simple error with the wrong vials will result in a fivefold overdose with potentially catastrophic results. That will usually not show up on the drug chart but may be suspected where a heparinised patient suffers a catastrophic bleed. Ideally, the infusion will be taken for analysis and staff questioned. Drug stocks may also be checked.

Some drugs **interact** with one another so that their effects are not merely added together but multiply one another. Everyone knows about the dangers of some sleeping pills and alcohol. There are numerous other fatal combinations. They are set out on each drug's data sheet.

There are a number of drugs which have a particularly **long** '**half-life**' (the time it takes for the body to metabolise – and so deactivate – one-half of the drug originally present). An example would be morphine. A patient may be given a slow overdose which accumulates in their body over days as they take the drug at a greater rate than the rate at which their body metabolises it.

That can lead to death, particularly where the person has other health problems. The size of the overdose may be modest and accumulate over some days.

There are drugs whose administration may lead to sudden or speedy death. As mentioned above, an **asthmatic** given a $\beta$ **-blocker** for an anxiety disorder or for high blood pressure may have a fatal asthmatic attack. A person with a **penicillin allergy** (or another drug hypersensitivity) may suffer from a fatal anaphylactic reaction. These drugs may have been administered in error and so may not be on the patient's drug chart. They may even be on a neighbouring patient's drug chart.

There are drugs which, if not administered promptly, may lead to the patient being put at severe risk. Certain post-operative antibiotics may be missed. An epileptic may accidentally have his or her anti-epileptic medication missed off their new drug chart when the old one is full and has to be copied out (often by the nursing staff) and signed (usually by the treating doctors).

One thing that sometimes receives scant attention is the **nursing care plan** where a patient is admitted to hospital. That may shed light on whether certain risks (e.g. of confusion leading to a fall) have been appreciated or adequately managed (e.g. by an instruction that bed rails always be raised, that a bed alarm be installed, etc.).

**Laboratory test results** are often very dull looking but may reveal a problem to an expert (or indeed to an inquisitive lay person). Usually, the normal ranges are set out in brackets beside each result. Abnormal results may well be significant.

**Fluid balance charts** show the administration of fluids and their amounts (what goes in) and the urine output and collection from operation site drains (what comes out). They should broadly balance. These charts should be read with the drug chart, which may contain drugs which affect fluid balance (e.g. diuretics) and with the **observations charts**. When your circulating blood volume reduces, your blood vessels contract, your urine output falls and you feel thirsty. Your heart rate will eventually start to increase and your blood pressure will eventually start to fall. The administration of fluids (including blood) may reverse these changes. If that reversal is temporary, then it may well be that fluid is being lost from somewhere. Post-operatively, the top concern will be of unrecognised bleeding.

Bleeding eventually (depending on its rate) may require blood transfusion and an operation to staunch it.

A significant and continuing fluid imbalance (between input and measured output) is a cause for concern.

Post mortem examination

It should be borne in mind that a post mortem examination is not a one-off. Very often, samples are retained and frozen. These include frozen sections of organs and frozen samples of blood, cerebrospinal fluid (CSF), stomach and gut contents and urine.

Toxicology and genetic testing can be carried out subsequently, if indicated. An expert instructed by the coroner or by the family may identify further tests and examinations which would assist in understanding the cause of death or its contributory factors.

Conclusion

Inquests following medical disasters require careful attention to all the available records and accounts in order, not only to diagnose the cause of death (which is usually straightforward), but also to uncover the chain of events which ended in the death, so that lessons can be learned and relatives may fully understand what happened to their loved one, how and why.

## THE AUTHOR

Dijen Basu QC studied medicine at the United Medical and Dental Schools of Guy's and St Thomas' and, in 1991, he was awarded a M.B., B.S. degree with Distinction in Surgery. He gained full registration with the General Medical Council (which he continues to hold today), and continued to practise on a locum basis thereafter to fund his legal training. As a medically qualified QC, Dijen regularly advises on, and acts in, complex and contentious matters connected with medicine, including employment disputes, regulatory and disciplinary issues, inquiries and inquests. He advises and appears in litigation, inquiries and inquests involving questions of law unique to the police. Dijen Basu QC is a member of the Attorney General's Panel of Special Advocates and has sat as a Recorder of the Crown Court for over 8 years.