



EUROPEAN COURT OF HUMAN RIGHTS  
COUR EUROPÉENNE DES DROITS DE L'HOMME

28 September 2010

**FOURTH SECTION**

Application no. 5878/08  
by Patricia ARMANI DA SILVA against the United Kingdom  
lodged on 21 January 2008

**STATEMENT OF FACTS**

**THE FACTS**

1. The applicant, Ms Patricia Armani Da Silva, is a Brazilian national who was born in 1974 and lives in Thornton Heath, London. She is represented before the Court by Ms Harriet Wistrech of Birnberg Peirce & Partners, a solicitor practising in London.

2. The application concerns the killing of her cousin, Jean Charles de Menezes, born on 7 January 1978, by officers of the Metropolitan Police Service (“MPS”) at Stockwell underground station in London on 22 July 2005.

**A. The circumstances of the case**

3. The facts of the case, as submitted by the applicant, may be summarised as follows.

*1. Background*

4. On 7 July 2005 four suicide bombers detonated explosions on the London transport network. Three were on underground trains and one was on a bus. 56 people were killed.

5. While it was quickly established that the four bombers had died in the explosions, a major police investigation began to establish the identities of any other persons connected to the explosions. The threat level posed to the United Kingdom from international terrorism was raised from Level 3 to

Level 1 as available intelligence indicated that terrorists were actively planning to attack within a matter of days. Levels of policing, particularly on the transport network, were significantly increased.

6. On 21 July 2005, precisely two weeks after the first bombings, four explosive devices were discovered in rucksacks, three on underground trains and one on a bus. They had failed to detonate. The police manhunt launched immediately for the failed bombers was led, as Gold Commander, by Police Commander John McDowall: he was already in charge of the investigation into the previous attacks. Later that evening, Commander McDowall held a command meeting: there was a fear that the individuals would re-group the following morning to cause explosions.

## *2. Operation THESEUS 2*

### **(a) The early hours of 22 July 2005 and Commander McDowall's strategy**

7. At 04.20 on 22 July 2005 Commander McDowall was informed that intelligence indicated that Hussain Osman with an address at 21 Scotia Road, London was a suspect. This address was also used by another suspect involved in the failed bombings of 21 July. The CCTV footage of the failed explosions and the photographs of Hussain Osman, and of another suspect, from their gym records were compared and found to be good likenesses.

8. At 04.38 on 22 July 2005 Commander McDowall decided to mount a surveillance operation (“THESEUS 2”) at 21 Scotia Road. Commander McDowall's strategy for this operation was to control the premises at Scotia Road through covert surveillance, follow any person leaving the premises until it was felt safe to challenge and then stop them. The overall aim was to establish whether the two suspects were present in the flat and if they came out to arrest them safely. A unit from SO19 (Special Firearms Officers, “SFOs”) was also to be in attendance at Scotia Road. SO19 provide specialist-armed support to the police and highly trained SFOs from SO19 are deployed on pre-planned operations.

9. Commander McDowall appointed Commander Cressida Dick as Designated Senior Officer (“DSO”) in charge and responsible for achieving the THESEUS 2 strategy safely as it was thought that an “Operation KRATOS scenario” could develop namely, one involving the implementation of a national strategy dealing with suspected suicide bombers potentially including the use of lethal force. She was supported in Control Room 1600 by Trojan 80 (an experienced SFO from SO19). Detective Chief Inspector C (“DCI C”) was also appointed as “Silver Commander”: while a Silver Commander would normally have ultimate responsibility for the management of an incident and deployment of firearms resources, on this occasion the DSO had such responsibility and DCI C operated as the DSO's ground commander. DCI C was also supported by and accompanied on the ground by Trojan 84; the latter was another experienced SFO from SO19; he was in charge of the SFO team to be deployed and he was in direct contact with Trojan 80. Detective Superintendent Jon Boucher (DS Boucher), the Senior Investigating Officer for the investigation into the identity of the persons responsible for the bombings on 7 July 2005, was also appointed as a Silver Commander. He

was to be the link between the Control Room and the Anti Terrorist Branch Officers (SO13) engaged in THESEUS 2.

10. By 06.04 on the same day two surveillance teams from SO12 were deployed to the Scotia Road address to control the premises and to follow anyone coming out of the block of flats. Although some were armed for their own protection and that of the public, the arms were not to be used to arrest armed suspects. An observation van had a view of the communal doorway to the block of flats (which included 17 and 21 Scotia Road). A log was maintained in the van and this information was passed on to relevant members of the surveillance teams. The Anti Terrorist Branch also deployed four officers to assist with any arrest and to gain intelligence.

11. At 06.40 Commander McDowall held a briefing with, *inter alia*, officers from the Anti Terrorist Branch and from SO19 (Trojan 80). At 06.50 he repeated this briefing for, *inter alia*, DCI C and with the DSO at 07.15. The Crown Prosecution Service (“CPS”) Review Note later noted that, if Commander McDowall’s strategy had been followed (notably, the deployment of the SFOs to support the surveillance teams at Scotia Road), events would not have unfolded as they did. At 07.45 Trojan 84 briefed the SFO team when they reported for duty. He added that the team “may be required to use unusual tactics because of the environment they were in and that they should think about this” and, when asked for clarification, Trojan 84 added that, in relation to a critical shot, the instruction would come direct from the DSO and if they were deployed to intercept a subject and there was an opportunity to challenge but the subject was non-compliant a critical shot could be taken. The CPS later found that this briefing “stoked the [SFOs] fears that they would meet suicide bombers and that they may have to shoot such people”.

**(b) Events leading to the death of Mr Jean Charles de Menezes**

12. Jean Charles de Menezes lived at 17 Scotia Road. At 09.33 he left the block of flats through the communal doorway for work. An officer in the surveillance van saw Mr de Menezes, described him and suggested “it would be worth someone else having a look”.

13. The team of SFOs had at some earlier stage travelled, stopping off for petrol on the way, to another police station at Nightingale Lane (about 2 miles from Scotia Road) where they received a further briefing from DCI C, commencing at 8.50. The CPS later criticised this briefing as unbalanced and as failing to caution the SFOs that they were to stop people leaving Scotia Road who would clearly not be suicide bombers and that they needed to ensure that they did not overreact in the heat of the moment. The SFO team were not deployed on the ground until after 09.30, by which time Mr de Menezes had already left his home.

14. On leaving Scotia Road Mr de Menezes walked the short distance to the bus stop and got on the bus. The CCTV on the bus did not record the entire journey due to vibrations but Mr de Menezes is recorded as on the bus by 09.39. At this point the surveillance team described him as “a good possible likeness” to the suspect, Hussein Osman. By 09.46 the description had changed to “not identical”.

15. At 09.47 Mr de Menezes got off the bus then ran back and got on again while using his mobile telephone. At this point there are conflicting

accounts of whether a positive identification of Mr de Menezes as the suspect was made. While those on the ground appear from the Stockwell One Report of the Independent Police Complaints Commission (the “IPCC”, and see paragraphs 29-31 below) not to have been able to identify Mr de Menezes as Hussein Osman and the Surveillance Running Log refers at every entry to the person as being an ‘U/I [unidentified] male’, those in Control Room 1600 appear to have believed that a positive identification of Hussein Osman had been made. At about this time, the SFOs began to make their way towards Brixton. At 09.59 the surveillance team were asked to give a percentage indication of the likelihood that he was the suspect and replied that it was ‘impossible [to do so] but thought that it was [the] suspect’.

16. Mr de Menezes got off the bus and walked towards the Stockwell underground station. At this time there were several surveillance officers in the vicinity and their leader offered to stop Mr de Menezes before he entered the station. The DSO initially ordered that they perform the stop as she had been informed that the SFOs were not in a position to intervene. However, having been immediately informed that the SFOs were on hand, she countermanded her original order and instructed the SFOs to stop Mr de Menezes. However, by this time, Mr de Menezes was in the underground station. Trojan 84 relayed the order to the SFOs informing them that “they want us to stop the subject getting on the tube” and the SFOs were told that they were going to Code Red, indicating that they were to have ultimate control of the situation and that an armed interception was imminent.

17. The CCTV at the station shows Mr de Menezes entering the station at 10.03 wearing a thin denim jacket, a T-shirt and denim jeans, walking calmly and not carrying anything. He went down an escalator and onto a platform. There is no CCTV recording of the lower end of the escalator or of the platform: the relevant tapes, when seized by the MPS, were blank. The IPCC Stockwell One Report and the CPS later found that this was because of a damaged cable due to recent refurbishment works.

18. At 10.05 a number of SFOs entered Stockwell underground station and ran down the escalators. At 10.06 they followed Mr de Menezes onto the platform. There are conflicting accounts as to what exactly then happened but it would appear from the accounts given in the IPCC Stockwell One Report that Mr de Menezes went into the third coach of a stationary train and sat down. One of the surveillance officers shouted to the SFOs that Mr de Menezes was there. Mr de Menezes then stood up, arms down, and, it would seem from the IPCC Stockwell One Report, that he was pushed back into his seat and pinned down by two police officers. The IPCC investigation team (Stockwell Two report) believed that Mr de Menezes did not refuse to obey a challenge and was not wearing any clothing that could be classed as suspicious. While several officers gave evidence suggesting that seconds later two SFOs shouted “armed police”, the Inquest jury (see paragraph 66 below) found that they had not done so.

19. Then, aiming at his head, the two SFOs (Charlie 2 and Charlie 12) shot Mr de Menezes several times in the head and killed him.

### *3. Post-death investigations*

#### **(a) The initial investigations**

20. On 23 July 2005 a post-mortem examination took place and recorded the cause of death as “multiple gunshot wounds to the head. The cause of death is severe disruption to the brain.”

21. Following the shooting, the Commissioner of the Police of the Metropolis wrote to the Home Office that the former had decided to exclude the IPCC from the scene and that the matter would not be referred to the IPCC. Since it was a police shooting, the Police Reform Act 2002 and the Police (Complaints and Misconduct) Regulations 2004 required a police shooting to be referred to the IPCC no later than the end of the working day following the day the conduct came to the attention of the appropriate authority.

22. While the Anti Terrorist Branch retained primacy at the scene, officers from the Department of Professional Standards (“DPS”) of the MPS, in accordance with post-incident procedure, ensured the integrity of the scene, interviewed witnesses and completed forensic retrieval. The two SFOs were taken to a police station. At 17.30 the SFOs advised that, having taken legal advice, they would not be making notes at that time. They made their statements together from approximately 14.00 the next day, at which point they knew that Mr de Menezes was not connected to the attempted bombings.

23. At 21.45 on 22 July 2005 the Anti Terrorist Branch formally handed over control of the scene to the DPS, as they were satisfied that Mr de Menezes was not connected to the attempted bombings.

#### **(b) The first IPCC investigation and the IPCC Stockwell One Report**

24. On 25 July 2005 the DPS formally referred the investigation to the IPCC. The investigation began on 27 July 2005 when the DPS provided the IPCC with the relevant material in its possession. The purpose of the investigation was to advise the CPS of any criminal offence that may have been committed and to provide it with the evidence necessary to come to its decision about any prosecution; to enable the “responsible authorities” of the officers concerned (the MPS and Metropolitan Police Authority, “MPA”) to consider what disciplinary or other action they may need to take; to inform the Home Secretary of the circumstances; and to assist the Coroner in relation to any Inquest.

25. Because of the seriousness of, and public interest in the matter, the IPCC determined that it would use its own staff to carry out the investigation. The members of the IPCC investigating team possess all the powers and privileges of a police constable for the investigation.

26. The IPCC was to investigate the circumstances in which Mr de Menezes was shot dead by police officers at Stockwell underground station including conducting the investigation and communicating its findings in a manner which sustained public confidence in the investigation process. It was to examine the information that led to the surveillance of the block of flats in Scotia Road; the command structure of the operation to include details of the numbers and types of specialist officers deployed and the tactics available to them; the qualification and training of those involved,

including the command team, and their suitability to carry out their role; details of the briefing given to the officers involved and any description or photograph of any suspect made available; whether or not the operation was designated as a “KRATOS” operation and the policy, operational tactics and authority levels of ‘KRATOS’; the details of the mobile surveillance operation from Scotia Road to Stockwell underground station; the details of police action once Mr de Menezes reached Stockwell underground station; whether or not the policy and operational authorities of “KRATOS” were followed and were effective and whether “KRATOS” was compliant with Article 2 of the Convention; to report on the actions and statements of the DPS from the time of the incident to the formal handover of the investigation to the IPCC to ensure that the IPCC investigation met its obligations under Article 2 of the Convention. Finally, the IPCC was to make recommendations regarding any possible criminal or misconduct culpability or learning/improvement opportunities revealed.

27. On 30 September 2005 the IPCC investigating team submitted a report to the IPCC indicating, *inter alia*, that certain officers might have committed criminal or disciplinary offences. The IPCC therefore wrote to the MPS and to the MPA about the officers concerned.

28. On 19 January 2006 the IPCC Stockwell One Report was completed and submitted to the CPS. On 6 and 22 March 2006 the legal representatives of Mr de Menezes were briefed on the IPCC investigation and Report. On 14 March 2006 the IPCC submitted its recommendations to the MPS, MPA, Her Majesty’s Inspector of Constabulary and to the Home Office.

29. The Report described in some detail the results of its investigations and, in so doing, it was critical of the delay in handing the investigation to the IPCC:

“17.22 The pressures under which the Metropolitan Police were operating following the events of 7 July and 21 July are self-evident. However, the fact that the independence body established by an Act of Parliament to the investigate complaints and serious incidents involving the police, and which has independently investigated every fatal police shooting since 1 April 2004 was now to be excluded from the scene, is a major concern for an independent investigation, and should never occur again.

17.23 The fact that there was such concern over the problems with the CCTV tapes at STOCKWELL and the fact that the hard drives on the train were missing highlights the problem. This issue could have been resolved a lot earlier had they been under the control of the IPCC.

17.24 The London and South East Regional offices are within 20 minutes driving time of STOCKWELL. While the organisation does not have all the resources of the DPS, a senior investigator could have been despatched to take command and control of the scene. It is fully recognised that the Anti Terrorist Branch may well have had primacy of the scheme, but a verbal memorandum of understanding concerning priorities could have been agreed at the time, as it would have been between [the Anti Terrorist Branch officer] and the DPS. ...

17.25 The failure to allow the IPCC access has also been highlighted by the fact that the surveillance log 165330 has been altered.”

30. The Report also identified a number of possible prosecutions for consideration by the CPS.

As to the translation of a “possible” to a “positive” identification, the IPCC noted that:

“However ‘James’ [the head of the surveillance team] did not communicate that some of his team thought that the subject was not [the suspect]. This information should have been fully communicated to [the DSO] as it may have influenced her decision-making. The [CPS] may wish to consider whether this negligence by ‘James’ ... satisfies the test for gross negligence.”

As to shooting Mr de Menezes after he had been tackled in the train:

“20.74 Charlies 2 and 12 clearly believe they were acting in self defence, and had the right in law to use the force they did. **The [CPS] may wish to consider whether the actions of Charlie 2 and Charlie 12 amount to murder in the context of their justification for the shooting of Mr DE MENEZES and having regard to the fact that there were explanations given for the shooting at that time which did not accord with the accounts given 36 hours later. ... An examination of whether any other officer, apart from Charlie 2 and Charlie 12, is potentially implicated in the shooting ... and whether any actions fall into any of the offence categories (other than murder) set out above. ...**

20.87 [The DSO] has endorsed that she was the person in command.

**The [CPS] may wish to consider whether the manner in which this operation was commanded, the failures to have resources properly deployed and the absence of any other tactical options could be considered to be grossly negligent.”**

As to any potential gross negligence of Charlie 2 and/or Charlie 12 in coming to the conclusion that de Menezes was a suicide bomber who had to be killed (manslaughter), the IPCC held as follows as regards all eight officers on board the train:

20.91 Given that they believed they were confronting a suicide bomber it is perhaps illogical that they would have challenged him prior to trying to detain him. The [CPS] may wish to consider whether any of the eight officers on the train who state they shouted or heard the words ‘armed police’ have conspired to ... pervert the course of justice. ...

and, specifically, as regards Charlie 2 and Charlie 12:

20.94 ... The [CPS] may wish to have regard to the matters summarised [above] in considering whether the actions of Charlie 2 and 12 amount to self-defence or not. They may also wish to consider whether they were grossly negligent to come to the conclusion that they were confronting a suicide bomber.”

As to the alteration of the surveillance log (see paragraph 29 above), the IPCC concluded that sufficient evidence had not been found against any individual to make it possible to suggest that criminal proceedings might be appropriate.

31. The IPCC also made detailed operational recommendations arising from the investigation, commenting at the outset:

“4.1 The IPCC fully concurs with the praise that the Metropolitan Police received for their handling of the events of 7 and 21 July 2005. The IPCC investigation into the death of Jean Charles DE MENEZES has however raised grave concerns about the effectiveness of the police response on 22 July 2005. Our concerns are not only, as in this case, the risk of an entirely innocent member of the public being killed in error but also whether the police response would stop a terrorist who was intent on causing harm.”

As to the police use of firearms, the IPCC made detailed recommendations on command and control issues including the need to clarify the roles and responsibilities within the chain of command; to establish a clear and common understanding of the circumstances surrounding future firearms operations; and to put in place better

communications channels given the failure to implement Commander McDowall’s strategy to ensure the deployment of the SFO team in time. The IPCC also underlined two operational concerns about the use of firearms: the substantial delay between the time the SFOs were requested and when they were deployed; and the lack of clarity about the command to “stop” the suspect given the likely mindset of the SFOs (they were deployed on an anti-terrorist operation the day after unsuccessful attempts had been made to cause explosions within the underground system. They had been issued with special ammunition for close range use. They knew a DSO was in command).

As to the surveillance operations, the IPCC was concerned that the surveillance team, the SFOs and those in command were not used to working together and were not sufficiently familiar with each others’ working practices; that two surveillance officers believed that the person being followed was not the suspect and that this was not communicated to the DSO; and that the surveillance log had been altered. Recommendations were made.

As to post-incident management, the IPCC repeated its concern about the delay in handing the scene and the investigation to it; about the fact that the SFOs (Charlie 2 and Charlie 12) were allowed to return to their own base, refresh themselves, confer and write up their notes together. Recommendations were made.

As to the communications infrastructure, the IPCC was concerned that command and control of the incident was inevitably lost when the SFOs entered the underground. Recommendations were made. As to training and exercises, concern was expressed that the existing ACPO Firearms Manual and the KRATOS policy were patently insufficient to deal with the current terrorist threat. Recommendations were made.

32. The IPCC Stockwell One Report was not made public until after the criminal prosecution of the Office of the Commissioner of the Police of the Metropolis (“OCPM”) as “the lawful, proper place to set out publicly the results of the IPCC investigation was therefore at the trial, in open court, in front of a jury”.

#### **(c) The second IPCC Investigation and IPCC Stockwell Two Report**

33. On 14 October 2005 the MPA referred a complaint about the MPS’s handling of public statements following the shooting of Mr de Menezes to the IPCC. The IPCC carried out a second investigation and the IPCC Stockwell Two Report was published on 2 August 2007. It concluded that there was insufficient evidence to conclude that any offences had been committed in relation to these complaints. However, it made a number of operational recommendations for the MPA and MPS.

#### *4. The first prosecution*

##### **(a) The first prosecutorial decision**

34. On receiving the IPCC Stockwell One Report, the CPS considered whether to bring prosecutions against any individual officers for murder, gross negligence manslaughter, misconduct in public office, forgery or



attempting to pervert the course of justice and against the OCPM for health and safety offences.

35. By letter dated 17 July 2006 the CPS notified the deceased's family that the DPP had decided to prosecute the OCPM, not in his individual capacity but as an employer of police officers, for failing to provide for the health, safety and welfare of Mr de Menezes contrary to the Health and Safety at Work etc Act 1974 ("the 1974 Act"). No individual was to be prosecuted in relation to the death as there was "insufficient evidence to provide a realistic prospect of conviction against any individual police officer", which phrase meant that a jury was more likely than not to convict. This decision letter, in so far as relevant, also provided as follows:

"... In the circumstances of this case, if the prosecution could prove that [the SFOs] were not acting in self defence (either of themselves or others) then they would be charged with murder. The order was given that Jean Charles was to be stopped from getting on the train. Although officers in the control room intended that Jean Charles should be arrested outside the station, the [SFO team] were not in place to make such an arrest, nor was this intention made explicit to the [SFOs] who were being sent down to the train. All the available evidence suggests that they believed that Jean Charles had been identified as a suicide bomber, that they had been directed to stop him from blowing up the train and that they had to shoot him to prevent that ...

The burden would be on the prosecution to prove beyond reasonable doubt that these two officers did not honestly and genuinely believe that they were facing a lethal threat and so I looked to see if there was sufficient evidence to disprove that they had such an honest and genuine belief. Both officers stated that Jean Charles was wearing a 'bulky' jacket when they saw him but in fact Jean Charles was wearing a simple denim jacket. I therefore took this into account as it could indicate that the officers had lied. However even if I could prove that the officers had lied, rather than simply being mistaken, this alone would not be enough to commence a prosecution for murder as there could be other reasons for an officer to lie. I also considered their explanations of Jean Charles's movements when they approached him, to see if there was evidence that they had fabricated those accounts to justify their actions. Both refer to Jean Charles getting up and advancing towards them with his hands down by his side before he was tackled by a surveillance officer and forced back into the seat. The [SFOs] then shot Jean Charles. I had to consider whether the prosecution could argue that the restraint meant that no bomb could be detonated and that the firearms officers' actions were unlawful. However I must bear in mind that this happened in a matter of seconds and there is some independent evidence that supports the officers' accounts that they feared Jean Charles might detonate a bomb. A witness sitting opposite Jean Charles said 'I got the impression that he was reaching to the left hand side of his trouser waistband.' ...

As I cannot prove the officers did not act in genuine self defence, I cannot charge them with murder or any other offence of assault, including manslaughter.

There is some disagreement between officers and the members of the public as to whether any warning was given that armed police were approaching the train. In a situation such as this, where a warning to a suspected bomber could be fatal for officers and the public, no warning should be given. However some police officers say that they did hear a call of 'armed police' before the shooting and although passengers did hear officers shouting as they ran down the stairs, none of them heard words 'armed police.' Both of the [SFOs] say that they shouted 'armed police' immediately before they fired but whether they did, and if so, whether it was intended as a warning to Jean Charles or to others in the carriage is unclear. There is no doubt that some police officers did shout something before any shots were fired .... Unless I could prove that officers had lied ... to mislead any investigation, I could not prosecute them for attempting to pervert the course of justice.

Next I carefully examined the roles of those police officers concerned in planning the surveillance and stop and those who carried it out. ... there were a number of people involved and there is no doubt that messages were misinterpreted with tragic consequences. I have considered whether any errors or other conduct by individuals could be categorised as criminal. In this I have applied the law on gross negligence manslaughter, misconduct in public office and the [1974] Act. Even where I found that individuals had made mistakes, I found insufficient evidence that those mistakes were so bad that they could be described as criminal. As criminal proceedings are to be brought against the [OCMP], I cannot provide you with a detailed account of the conduct of those individuals, as that conduct will form part of the prosecution case.”

36. More detailed reasons were provided in an extensive (50 pages) Review Note dated 9 March 2006 as well as in a Final Review Note of 9 July 2006. All relevant frontline and surveillance officers’ acts and omissions were examined in detail including those of the two SFOs who had shot Mr de Menezes (Charlie 2 and Charlie 12), the DSO and her tactical officer (Trojan 80), the DCI C and his tactical officer (Trojan 84, considered by the CPS to have been the officer most closely connected to Mr de Menezes’ death) as well and the surveillance teams. Offences of murder, gross negligence manslaughter, misconduct in public office, forgery and attempting to pervert the course of justice were considered.

37. The alleged alteration of the log had been examined by two experts who did not agree to the required standard as to whether there were alterations or, if there were, who may have made them. Since it could not be proved that it was a forgery, let alone who would have done it, there was no basis for a prosecution of conspiracy to pervert the course of justice.

38. While there were a number of evidential gaps in the recording equipment on the bus, at the station and on the train, the IPCC investigation had revealed that high vibrations interfered with the recording of most of the bus journey, the hard drive on the train had not been replaced on the relevant day and the recording equipment in the station had been broken during prior refurbishments. There was therefore no evidence that the police or anyone else had tampered with those recordings.

39. As to the OCPM, being a corporate employer within the meaning of the 1974 Act, the question was whether it was reasonably practical for the OCPM to have acted in a way that would not have exposed Mr de Menezes to the risk of being shot. The CPS Review Note continued:

“The answer seems obvious. First, the manuals are flawed as they do not cover the situation of the innocent but mistakenly identified individual (as occurred here) but perhaps more importantly, there was no plan in place to stop “Suspect 1” safely. It can easily be seen that if Suspect 1 had left Scotia Road wearing a bomb, such device could have been detonated on the bus. It would have been possible for the [OCPM] to have argued that it was not “reasonably practicable” to have prevented such an occurrence.

A visit to Scotia Street reveals that the opportunity was there to conduct a safe stop using police vehicles. S019 had over three hours to deploy, yet the lack of the sense of urgency is highlighted by stopping off for petrol [on the way]. The fact that the surveillance team got there shortly after 6.00am shows that it was “reasonably practicable” for S019 to have done so. In my opinion, the offence under section 3 [of the 1974 Act] is made out.”

40. The evidential test being met, there was a presumption of a prosecution unless the public interest factors against prosecution “clearly outweigh” those in favour: The Review Note continued:

“In my view, this operation was badly handled from the moment it passed from Commander [McDowall]. It resulted in an innocent man being shot dead in the most horrific manner. The Metropolitan Police were under tremendous pressure and were doing their best to protect the public from suicide bombers. These are factors that I take into account but these do not detract from the failure to carry out [Commander McDowall’s] strategy which would have best protected Mr de Menezes.”

41. The only defence open would be one of “reasonable practicability” and it was:

“difficult to see how the police could argue the lack of reasonable practicability in ensuring the safety of [Mr de Menezes]. If this came to a contested trial, the police would probably have to call a number of officers ... who were interviewed as suspects. Their failures in the planning would then be highlighted.”

42. In reviewing the Health and Safety Executive Policy in relation to employers, the Review Note continued:

“... in my view in this instance the failures were serious, avoidable and led to the death of an innocent man.

In my view, the lack of planning led to the death of de Menezes and, as such, constituted an offence under section 3 of the [1974 Act]. I believe that if such a charge is preferred, we can prove the case on the evidence already available but a decision not to prosecute individuals will enable the IPCC to seek further evidence to strengthen the case, from those individuals who are at present declining to.”

#### **(b) Judicial review of the first prosecutorial decision**

43. On 16 October 2006 the applicant applied for leave to apply for judicial review of the decision not to prosecute any individual police officer for criminal offences. It was dismissed by a Divisional Court of the High Court on 14 December 2006 (*R (on the application of da Silva) v. DPP and the IPCC* [2006] EWHC 3204 (Admin)).

44. The applicant argued that the failure to prosecute individual officers violated Article 2 of the Convention, that the evidential test in the Crown Prosecutors Code (“the Code”) was incompatible with Article 2 as it prevented a prosecution where a jury properly directed could convict and Article 2 required a court to undertake a more intensive review of the prosecution decision than that laid down in the *Manning* case (*R. v. Director of Public Prosecutions, ex p Manning* [2001] 1 QB 330).

45. In relation to the compatibility of the Code with Article 2, the High Court found that the jurisprudence of this Court did not determine any particular evidential test to be applied when deciding whether there should be a prosecution. The test propounded by the Code was compatible with the obligation under Article 2 to put in place effective criminal law provisions to deter the commission of offences against the person, backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions: bringing prosecutions which were likely to fail, even if they could survive a dismissal application and a submission of no case to answer, would not enhance the effectiveness of these provisions and would undermine public confidence in the system.

46. In relation to the standard of review by the courts of a prosecutorial decision, the High Court held that Article 2 did not require a change to the established position regarding judicial review of a decision not to prosecute. The “careful scrutiny” review required in *Öneryıldız v. Turkey* (no. 48939/99, § 96, 18 June 2002) was compatible with the test outlined in the

domestic *Manning* case (the decision was lawful if it was taken in accordance with the Code and was a decision reasonably open on the material before him, see paragraph 80 below) and with the domestic courts' general approach to cases involving fundamental human rights.

47. Thirdly, and applying the *Manning* test, the High Court found that the decision of the CPS was in accordance with the Code and reasonably open to the CPS. The decision was taken by a very senior and highly experienced prosecutor and it was reviewed by the DPP himself and by leading counsel. It was lengthy, careful, thorough, clear and detailed and the CPS applied the correct test to each individual considered namely "whether there was sufficient evidence to provide a realistic prospect of conviction, i.e. whether a jury was more likely to convict than not to convict".

48. The Court therefore concluded that the decision not to prosecute was lawful. Leave to appeal to the House of Lords was refused by the High Court and, on 26 July 2007, by the House of Lords.

49. On 22 January 2007 the High Court also rejected an application to have the charges under the 1974 Act dismissed. The applicant has not submitted this decision.

**(c) The prosecution of the OCPM**

50. On 1 October 2007 the criminal trial of the OCPM commenced. The prosecution argued that the OCPM was guilty of the following faults:

(a) failure adequately to communicate Commander McDowall's strategy to the officers who took over the running of the operations on 22 July 2005, the surveillance officers and the [SFOs];

(b) failure adequately to plan for or carry out Commander McDowall's strategy for controlling the premises;

(c) the control room officers, the SFOs and the surveillance officers had a confused and inconsistent understanding of what the strategy was for Scotia Road;

(d) failure to deploy officers to stop and question persons emerging from the Scotia Road premises, including Mr de Menezes;

(e) failure to ensure that the SFOs were in attendance at Scotia Road when Mr de Menezes emerged from the common doorway;

(f) failure to have a contingency plan for dealing with persons who emerged from the block of flats before firearms officers arrived;

(g) failure to stop and question persons emerging from Scotia Road;

(h) failure to identify a safe and appropriate area where those leaving Scotia Road could be stopped and questioned;

(i) the briefings given to the SFOs were inaccurate, unbalanced, and provided the SFOs with inadequate and inaccurate information about the operation including the operation at Scotia Road;

(j) the information as to the identification of Mr de Menezes, his clothing, demeanour and likely level of threat, was not properly or accurately assessed or disseminated to officers and, in particular, to the SFOs;

(k) failure to ensure that doubts about the correctness of the identification of Mr de Menezes as the suspect were communicated to the control room;

(l) the control room officers failed to satisfy themselves that a positive identification of Mr de Menezes as the suspect had been made by the surveillance officers;

(m) failure to deploy the SFOs at relevant locations in time to prevent Mr de Menezes from getting on the bus and entering Stockwell underground station;

(n) the SFOs failed to satisfy themselves that a positive identification of Mr de Menezes as the suspect had been made by the surveillance officers;

(o) failure to take effective steps to stop underground trains or buses or take other traffic management steps so as to minimise the risk to the travelling public;

(p) Mr de Menezes was twice permitted to get on a bus and to enter Stockwell underground station despite being suspected of being a suicide bomber and despite having emerged from an address linked to a suspected suicide bomber;

(q) failure to give a clear or timely order that Mr de Menezes be stopped or arrested before he entered Stockwell underground station;

(r) failure to give accurate information to the DSO as to the location of the SFOs when she was deciding whether the SFOs or officers from the Anti Terrorist Branch should stop Mr de Menezes; and

(s) failure to minimise the risk inherent in effecting the arrest of Mr de Menezes by armed officers whether in relation to the location, timing or manner of his arrest.

51. On 1 November 2007 the jury returned a verdict finding the OCPM guilty of breaching sections 3 and 33 of the 1974 Act as alleged by the prosecution. The jury also attached a rider to their verdict to the effect that the DSO bore no “personal culpability” for the impugned events, which rider was endorsed by the trial judge. The sentence imposed was a fine of GBP 175,000 and the OCPM was ordered to pay costs of GBP 385,000.

#### *5. Disciplinary proceedings against the frontline and surveillance officers.*

52. On 11 May 2007 the IPCC decided that no disciplinary action should be pursued against any of the frontline and surveillance officers (11 officers) involved in the operation since there was no realistic prospect of any disciplinary charges being upheld. One surveillance officer received “words of advice” for the alteration of the surveillance log. A decision as regards disciplinary charges against the remaining four, the commanders and their tactical advisors, would be taken after the prosecution of the OCPM. The applicant has not submitted this decision.

#### *6. The Inquest*

53. The Inquest had been adjourned pending the trial of the OCPM, which decision the High Court upheld in December 2006. On 22 October 2008 the Inquest recommenced.

54. On 24 November 2008 the Coroner delivered a written Ruling as regards what, if any, verdicts should be left to the jury (the options being lawful killing, unlawful killing and an open verdict). In his Ruling, the Coroner noted that it was common ground that, in deciding which verdicts

to leave open, he could have regard to the previous decision not to prosecute any individual, subject to a number of qualifications. The test he had to apply in refusing to leave a verdict to a jury was different from the test of whether to prosecute and his decision had to be made in light of any further evidence that had come to light since that decision. While he could not leave a verdict to a jury which would be inconsistent with the OCPM trial, there was no real scope for inconsistency between the findings of the Inquest and the verdict or rider in the OCPM trial so that that trial did not, of itself, exclude a verdict. He then proceeded to consider the verdicts to be left to the jury separately as regards certain police officers.

**(a) As to the SFOs (Charlie 2 and Charlie 12) who shot Mr Menezes**

55. The Coroner found that,

“16. ...There is no doubt that the officers intended to kill Mr de Menezes when they fired. Therefore, if their contention that [they] were acting lawfully in defence of themselves or others could be disproved, they would have committed ... the offence of murder.

17. There is agreement between all Interested Persons as to what test I should apply in determining whether the officers acted lawfully in defence of themselves and others:

(i) Did the officer honestly and genuinely believe that it was necessary for him to use force in defence of himself and/or others? This is a question of subjective belief. Even if the belief was mistaken, and even if the mistake was unreasonable, the defence can still run. The reasonableness of the belief is only relevant in helping the jury to decide whether the belief was honestly held.

(ii) If the officer did hold the belief, did he use no more force than was reasonably necessary in the circumstances as he believed existed at the time? This is an objective test, but it is applied realistically. Where a person faces a threat, the Courts will not judge with too precise a measure the degree of force he uses... It is also significant for present purposes that a person under threat is not required to wait passively for the blow to fall. A pre-emptive strike can be justified by the circumstances.

56. It was accepted that the SFOs honestly believed that the man in front of them in the carriage was Hussain Osman, the person who was strongly suspected of having attempted to explode a bomb on the underground the day before. The Coroner further rejected the submission on behalf of the de Menezes family that the officers did not honestly believe that Mr de Menezes represented an imminent threat based on inconsistencies in their evidence. He concluded that the jury could not properly conclude to the criminal standard of proof that the two officers did not honestly believe that Mr de Menezes represented a mortal threat to those around them. In reaching that conclusion, he stated that he was ‘fortified’, in the first place, by the fact that the High Court had said that the decision not to prosecute the officers was not only reasonable but “manifestly the correct one in all the circumstances of this case” and, secondly, because it was difficult to see why the officers acted as they did if they did not truly believe Mr de Menezes represented a threat. In relation to this latter point, he concluded:

“27. If the officers honestly believed that Mr de Menezes represented a mortal threat to themselves and those around them, it could not be said that they used more force than was reasonably necessary... An argument was made... to the effect that [one of the officers] used excessive force because he fired too many times ... In my judgment, it has no merit. The events took place in a few seconds, and one cannot fairly say that

some of the shots to the head constituted reasonable force and some did not. In any event, the officers had been trained to fire until the threat was neutralised.

**(b) As to the senior officers**

57. He then considered whether the senior officers could safely be found to have committed gross negligence manslaughter. It was accepted by all parties that the offence had to be proved against a particular officer (one could not aggregate the failings of persons). Four additional matters had to be proved in order to establish that the offence had been committed: the defendant must have owed a duty of care to the victim, the defendant must have breached that duty, the breach must have caused the death (namely, made a more than minimal causal contribution to death) and the breach must be characterised as “gross”.

58. In relation to the duty of care, the Coroner concluded that,

“35... a police officer can owe a duty of care in directing other police officers to perform an armed interception. The content of the duty here would be to take reasonable care to ensure that such an interception took place in such a location and at such a time as to minimise, so far as reasonably practicable, the risk of unnecessary injury to the subject of the intervention, to the officers concerned and to others in the immediate vicinity. In this case the duty would not arise before the point at which firearms officers were ordered to move through with a view to performing an interception.

*(i) Commander McDowall*

59. In relation to Commander McDowall, there were three alleged breaches of a duty of care. The Coroner gave detailed reasons why he did not accept that this officer had breached any duty of care to Mr de Menezes.

*(ii) the DSO*

60. There were three allegations against her:

“54... First, ... that [the DSO] failed to ensure that the block on Scotia Road was kept under careful surveillance control and that tactics were employed to ensure that all suspects could be identified and stopped before reaching a bus stop. As it happens, the nearest bus stop was on Upper Tulse Hill, only a few minutes’ walk from the block. The first obstacle [to this] argument is the difficulty of constructing a positive duty of care at that stage to stop Mr de Menezes close to his home. In my judgment, no such duty could exist. Even if it could, I consider that it would not have been practicable to implement this as a fixed and inflexible tactical plan... In any event, the surveillance control was good: Mr de Menezes was kept continually under surveillance but the covert status of the operation near Scotia Road was maintained. The failure to stop him at an earlier stage was based on an inability of officers to say whether he was identifiable with the suspect. Therefore, his death was not caused by any failure of surveillance control at Scotia Road.

55. Secondly, it is alleged that [the DSO] failed to keep herself informed of where surveillance and firearms officers were as Mr de Menezes was travelling from Tulse Hill towards Stockwell. Again, I do not think that a police officer owes a duty to a person under surveillance to ensure that he is informed of the movements of other officers, at least before any intervention is immediately in prospect. If there were such a duty, it would only be to keep oneself reasonably well-informed, since it would not be practicable to keep note of the precise position of every officer and car. The thrust of the evidence is that [the DSO] did keep herself reasonably well-informed. She was aware, through the surveillance monitor in the control room, that surveillance officers were following Mr de Menezes and of what they were saying. In any event, as Mr Mansfield accepts, nothing could have been done to stop Mr de Menezes between his

getting on the bus at Tulse Hill and his alighting at Stockwell. [The DSO] had [the SFOs] at the proper holding point at the time she wanted to deploy them. In the minutes before she ordered the intervention, she was relying upon information from [her tactical advisor] as to the position and readiness of the [SFOs]. In my judgment, she was entitled to rely upon that information. In all those circumstances, any failure on her part to keep herself informed was not causative of the fatal events in the carriage.

56. Thirdly, it is submitted ... that [the DSO] failed to exercise proper judgment in her decisions in the last critical minutes, after Mr de Menezes left the bus at Stockwell. In my judgment, she probably did owe a duty of care to him at this stage in making decisions and giving directions for an armed stop. However, she cannot fairly be said to have breached that duty. When she became aware that the subject of surveillance had left the bus, she ordered the [SFOs] to perform an armed stop. Upon hearing that they were not in a position to make the stop, she instructed the surveillance officers to do so. That order cannot be characterised as negligent. If there were any slight delay in giving the order, that can probably be explained by the need to take thought before ordering a suspected suicide bomber to be stopped by officers who were not trained for such situations. Once she was told that the [SFOs] were in position, she countermanded the earlier order. It might be possible to say that she made the wrong decision at that point, given where Mr de Menezes was known to be, but these were fast-moving events and her decision cannot be described as negligent. [It was submitted] that using [SFOs] gave rise to a particular risk that lethal force would be used. However, there were obvious advantages to using officers who had the training and experience to perform armed interventions in a public place.”

*(iii) Trojan 80 (the DSO's firearms tactical adviser)*

61. As to this officer, the Coroner stated as follows:

“58. The first charge against [Trojan 80] is that, upon arriving at New Scotland Yard at around 6am, he failed to take steps to expedite the despatch of [the SFOs] to the Scotia Road area. For the reasons already given, I do not consider that he would have owed a duty of care to Mr de Menezes in this regard. In any event, when he started work, all the critical decisions had been taken in relation to the [SFOs] deployments. It would probably not have been safe or sensible to try to expedite the deployments at that stage. As explained in paragraph 52 above, I do not think it can be established to the necessary standard of proof that any delay in deploying firearms teams was causally relevant to the death of Mr de Menezes.

59. The second allegation is that he failed to devise a tactical plan to ensure that any suspect coming out of the block was stopped before reaching a bus stop. This is, in essence, the same as one of the allegations made against [the DSO]. For the reasons I have given in paragraph 54, this argument fails at every stage.

60. The third point made in criticism of [Trojan 80] is that he failed to pass on to [the DSO] accurate information about the position of the [SFOs] in the minutes after it became apparent that Mr de Menezes was leaving the bus. However, [Trojan 80] was reliant for his information on the tactical adviser who was with the team on the ground, ‘Trojan 84’. That officer initially told [Trojan 80] that his team were ‘not in contention’ because they were behind the wrong bus. [Trojan 80] duly passed on that information. Even if it were incorrect, it is difficult to criticise him for passing it on.”

62. If, contrary to all of the above, any of the allegations were made out, the Coroner concluded that none approached the level of gross or criminal negligence. The Coroner therefore decided not to leave the potential short-form verdict of “unlawful killing” open to the jury and thereby left them only with a verdict of “lawful killing” and an “open verdict”.

63. The Coroner also included in his Ruling a list of proposed questions which would be left to the jury and which required a yes/no/cannot decide response. Having heard the parties’ submissions, on 1 December 2008 he



finalised the questions of fact concerning the events in the train carriage and those concerning the contributing factors, in order to elicit their views as to the circumstances and events which made some causal contribution to the death of Mr de Menezes, but he refused to leave “open questions” to the jury inviting them to add any other factors they regarded as causally relevant.

64. On 12 December 2008 the jury returned an “open verdict”. The jury also answered the questions left to them as follows:

(i) that [Charlie 12] did not shout “armed police”;

(ii) that, while Mr de Menezes did stand up before being grabbed in a bear hug by one of the surveillance officers, he did not move towards the SFOs;

(iii) that the general difficulty in providing identification of the man under surveillance in the time available and the innocent behaviour of Mr de Menezes increasing suspicion were not contributory factors to the death;

(iv) that the failure to obtain and provide better photographic images of failed bomber Hussain Osman to surveillance officers; the fact that the views of the surveillance officers regarding identification were not accurately communicated to the command team and the SFOs; the failure by police to ensure that Mr de Menezes was stopped before he reached public transport; the fact that the position of the cars containing the SFOs was not accurately known by the command team as SFO teams were approaching Stockwell Tube; shortcomings in the communications system between various police teams on the ground; and a failure to conclude at the time that surveillance officers could have been used to carry out the stop on Mr Menezes at Stockwell, were each contributory factors to the death. The jury could not decide whether the pressure on police after the suicide attacks in July 2005 was a contributory factor to Mr de Menezes’ death.

#### *7. Judicial review of Coroner’s decision on verdicts open to the jury*

65. On 2 December 2008 Mr de Menezes’ mother sought leave to apply for judicial review in the High Court of the Coroner’s exclusion of the “unlawful killing” verdict and of certain narrative verdict questions. At the hearing, she pursued the second point only because, by the date of the judicial review hearing, the Coroner had already started summing up and had already indicated the only verdicts which were to be left to them.

66. The applicant argued that the Coroner was obliged to ensure that the jury members were permitted to resolve the disputed factual issues at the heart of the case and were able properly to determine by what means and in what circumstances Mr de Menezes came by his death and that the question of how he came by his death went far beyond determining whether this concerned “lawful killing” or an “open verdict”; that the Coroner’s approach precluded the jury from commenting on whether they regarded any particular failings by the police as serious and, if so, how serious and this was important in terms of accountability; and that the Coroner’s approach meant that the jury’s findings were at best likely to beg more questions and at worst be confusing or meaningless. The claimant therefore wished to put additional narrative verdict questions to the jury once the Coroner’s summing up was finished

67. On 3 December 2008 Silber J refused leave to apply for judicial review (*R(on the application of D) v. The Assistant Deputy Coroner for Inner South London* [2008] EWHC 3356 (Admin)), giving six reasons.

In the first place, the existing verdicts and questions enabled the jury to satisfy their statutory obligations (section 11 of the Coroner’s Act and Rule 36(1)(b) of the Coroner’s Rules) and to ascertain by what means and in what circumstances Mr de Menezes came by his death. The verdicts of the jury in this case provided, furthermore, more information than was sought from, and given by, the jury in *Bubbins v. the United Kingdom* (no. 50196/99, ECHR 2005-II) and *McCann and Others v. the United Kingdom* (27 September 1995, Series A no. 324) where this Court found that the procedural obligations under Article 2 of the Convention had been met.

Secondly, no case decided domestically or in this Court had been cited in which it was held that specific questions, whether of the kind sought by the claimants in the case or otherwise, were required to be asked of a jury over and above asking them “by what means and in what circumstances” the deceased died. Thirdly, the Coroner had a discretion “to decide how best in the particular case to elicit the jury’s conclusion on the central issue or issues” and therefore the only grounds for interfering would probably be on *Wednesbury* grounds. Fourthly, there was a risk that if the jury were required to answer the additional questions proposed they would be acting in contravention of Rule 36(2) of the Coroners Rules 1984 by expressing opinions on matters other than those on which they were entitled to comment and, in particular, by appearing to determine questions of criminal or civil liability. Fifthly, the proposed questions would expose the jury to a risk of making contradictory and conflicting findings. Sixthly, the claimant had failed to show, even arguably, that there were strong grounds for disturbing the decision of the Coroner.

68. The claimant’s grounds relating to the short-form verdicts were adjourned generally with liberty to both parties to apply to restore. The applicant subsequently agreed that no further action would be taken in these respects because, *inter alia*, even if the judicial review was successful, the only remedy for the family would be for the court to order a fresh Inquest and the claimant did not “see any great benefit in re-hearing all the evidence to enable a different jury to come to a verdict, particularly bearing in mind the very high cost of holding such an inquest”.

#### 8. *The second prosecutorial decision*

69. Following the Inquest, further meetings and exchanges of correspondence took place between the CPS and Mr de Menezes’ family. On 26 March 2009 the family requested the DPP (the head of the CPS) to review the decision not to prosecute given new evidence which had emerged at the Inquest.

70. On 8 April 2009 the DPP confirmed by letter that there remained insufficient evidence to prosecute any individual.

71. The applicant did not apply for leave to seek judicial review of this decision, considering that there were no prospects of success in the light of the previous judicial review action. The factual matrix had not significantly changed: the claim would have been on similar grounds to the previous claim for review and was therefore bound to fail.

### 9. *Second refusal to initiate disciplinary proceedings*

72. By letter dated 2 October 2009 the IPCC rejected the family's request to review its decision not to initiate disciplinary proceedings as there was no new evidence which had emerged during the Inquest that would justify bringing disciplinary charges against any individual officer.

73. On 2 October 2009 the Chairman of the IPCC rejected the family's submissions that new evidence emerging from the Inquest supported the issuance of disciplinary proceedings. The trial of the OCPM and the Inquest had confirmed the conclusion of the IPCC that Mr de Menezes was killed because of mistakes that could and should have been avoided. Indeed, the trial of the OCPM, the Coroner's Report, the IPCC recommendations, Her Majesty's Inspectorate of Constabulary, the MPA and the MPS had all recognised the organisational failings that led to his death. Major efforts had been made to rectify them and it was necessary to take these organisational failings into account when judging the individual culpability of the officers concerned. Every independent judicial, prosecuting and disciplinary authority who has considered the conduct of the officers had concluded that individual criminal or disciplinary charges were not merited. He concluded, having examined separately the cases of, *inter alia*, Commander McDowall, the DSO, the SFOs (Charlie 2 and Charlie 12), Trojan 80 and Trojan 84, that no disciplinary charges were warranted.

### 10. *A civil action for damages*

74. A civil action in damages was brought by the family of Mr de Menezes including the applicant against the Commissioner of Police of the Metropolis. This was settled by way of mediation during the week of 16 November 2009. While the settlement was on a confidential basis, the amount was reported in the press as just over 100,000 pounds sterling (*The Guardian*, 23 November 2009).

## **B. Relevant domestic law**

### 1. *Prosecutorial decisions*

75. The circumstances in which the CPS will pursue a prosecution are governed by the Prosecution of Offences Act 1985 ("the 1985 Act") and by the Code.

#### **(a) 1985 Act**

76. Section 10 of the 1985 Act provides:

"(1) The [DPP] shall issue a Code for Crown Prosecutors giving guidance on general principles to be applied by them—

(a) in determining, in any case—

(i) whether proceedings for an offence should be instituted or, where proceedings have been instituted, whether they should be discontinued;  
or

(ii) what charges should be preferred; and

(b) in considering, in any case, representations to be made by them to any magistrates' court about the mode of trial suitable for that case.

(2) The Director may from time to time make alterations in the Code...”

**(b) The Code for Crown Prosecutors (“the Code”)**

77. The relevant sections of the Code read as follows:

“5. THE FULL CODE TEST

5.1 The Full Code Test has two stages. The first stage is consideration of the evidence. If the case does not pass the evidential stage it must not go ahead no matter how important or serious it may be. If the case does pass the evidential stage, Crown Prosecutors must proceed to the second stage and decide if a prosecution is needed in the public interest. The evidential and public interest stages are explained below.

THE EVIDENTIAL STAGE

5.2 Crown Prosecutors must be satisfied that there is enough evidence to provide a ‘realistic prospect of conviction’ against each defendant on each charge. They must consider what the defence case may be, and how that is likely to affect the prosecution case.

5.3 A realistic prospect of conviction is an objective test. It means that a jury or bench of magistrates or judge hearing a case alone, properly directed in accordance with the law, is more likely than not to convict the defendant of the charge alleged. This is a separate test from the one that the criminal courts themselves must apply. A court should only convict if satisfied so that it is sure of a defendant’s guilt.

5.4 When deciding whether there is enough evidence to prosecute, Crown Prosecutors must consider whether the evidence can be used and is reliable. ...

THE PUBLIC INTEREST STAGE

4.11 Accordingly, where there is sufficient evidence to justify a prosecution or to offer an out-of-court disposal, prosecutors must go on to consider whether a prosecution is required in the public interest.

4.12 A prosecution will usually take place unless the prosecutor is sure that there are public interest factors tending against prosecution which outweigh those tending in favour, or unless the prosecutor is satisfied that the public interest may be properly served, in the first instance, by offering the offender the opportunity to have the matter dealt with by an out-of-court disposal (see section 7). The more serious the offence or the offender’s record of criminal behaviour, the more likely it is that a prosecution will be required in the public interest.

4.13 Assessing the public interest is not simply a matter of adding up the number of factors on each side and seeing which side has the greater number. Each case must be considered on its own facts and on its own merits. Prosecutors must decide the importance of each public interest factor in the circumstances of each case and go on to make an overall assessment. It is quite possible that one factor alone may outweigh a number of other factors which tend in the opposite direction. Although there may be public interest factors tending against prosecution in a particular case, prosecutors should consider whether nonetheless a prosecution should go ahead and for those factors to be put to the court for consideration when sentence is passed.

4.15 Some common public interest factors which should be considered when deciding on the most appropriate course of action to take are listed below. The following lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.

**Some common public interest factors tending in favour of prosecution**

4.16 A prosecution is more likely to be required if:

a) a conviction is likely to result in a significant sentence; ...

- c) the offence involved the use of a weapon or the threat of violence; ...
- j) the victim of the offence was in a vulnerable situation and the suspect took advantage of this; ...
- n) the suspect was in a position of authority or trust and he or she took advantage of this; ...
- r) a prosecution would have a significant positive impact on maintaining community confidence; ...

**Some common public interest factors tending against prosecution**

4.17 A prosecution is less likely to be required if:

- a) the court is likely to impose a nominal penalty;
- b) the seriousness and the consequences of the offending can be appropriately dealt with by an out-of-court disposal which the suspect accepts and with which he or she complies ...;
- c) the suspect has been subject to any appropriate regulatory proceedings, or any punitive or relevant civil penalty which remains in place or which has been satisfactorily discharged, which adequately addresses the seriousness of the offending and any breach of trust involved;
- d) the offence was committed as a result of a genuine mistake or misunderstanding;  
...
- g) a prosecution is likely to have an adverse effect on the victim's physical or mental health, always bearing in mind the seriousness of the offence and the views of the victim about the effect of a prosecution on his or her physical or mental health;
- h) the suspect played a minor role in the commission of the offence;
- i) the suspect has put right the loss or harm that was caused (but a suspect must not avoid prosecution or an out-of-court disposal solely because he or she pays compensation or repays the sum of money he or she unlawfully obtained); ...”

**(c) Review of prosecutorial decisions: *R. v. Director of Public Prosecutions, ex p Manning* [2001] 1 QB 330**

78. A specialist senior caseworker in the CPS took a decision not to prosecute any officers for any offence arising out of the death of a person in prison custody while under restraint by prison officers and after a Coroner's Inquest had returned a verdict of unlawful killing, on the basis that he was not satisfied that the evidential test under the Code would be met. A Divisional Court of the High Court quashed the decision. After describing the evidential test, Lord Bingham of Cornhill CJ, giving the judgment of the court stated:

“23. Authority makes clear that a decision by the Director not to prosecute is susceptible to judicial review ... . But, as the decided cases also make clear, the power of review is one to be sparingly exercised. The reasons for this are clear. The primary decision to prosecute or not to prosecute is entrusted by Parliament to the [DPP] as head of an independent, professional prosecuting service, answerable to the Attorney General in his role as guardian of the public interest, and to no-one else. It makes no difference that in practice the decision will ordinarily be taken by a senior member of the CPS, as it was here, and not by the [DPP] personally. In any borderline case the decision may be one of acute difficulty, since while a defendant whom a jury would be likely to convict should properly be brought to justice and tried, a defendant whom a jury would be likely to acquit should not be subjected to the trauma inherent in a criminal trial. If, in a case such as the present, the [DPP's] provisional decision is not to prosecute, the decision will be subject to review by senior Treasury counsel who will exercise an independent professional judgment. The [DPP] and his officials ...

will bring to their task of deciding whether to prosecute an experience and expertise which most courts called upon to review their decisions could not match. In most cases the decision will turn not on an analysis of the relevant legal principles but on the exercise of an informed judgment of how a case against a particular defendant, if brought, would be likely to fare in the context of a criminal trial before (in a serious case such as this) a jury. This exercise of judgment involves an assessment of the strength, by the end of the trial, of the evidence against the defendant and of the likely defences. It will often be impossible to stigmatise a judgment as wrong even if one disagrees with it. So the courts will not easily find that a decision not to prosecute is bad in law, on which basis alone the court is entitled to interfere. At the same time, the standard of review should not be set too high, since judicial review is the only means by which the citizen can seek redress against a decision not to prosecute and if the test were too exacting an effective remedy would be denied. ...

41. ... We accord great weight to the judgment of experienced prosecutors on whether a jury is likely to convict, and Mr Western's [the decision maker] review note does not at all read as if composed to reach a pre-determined conclusion; the note suggests that the author was seeking to review the case fairly and even-handedly, and the final conclusion against prosecution comes as something of a surprise. In the end we are, however, satisfied that there are five points which [the] defendant would have to overcome if he were to defeat the prima facie case which in Mr Western's judgment lay against him and there were points which Mr Western did not address and resolve... ”

## 2. *Health and Safety at Work etc. Act 1974 (“the 1974 Act”)*

79. Section 3(1) of the 1974 Act reads as follows:

“It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.”

80. Section 33(1)(a) of this Act provides that it is an offence for a person to fail to discharge a duty to which he is subject by virtue of, *inter alia*, section 3 of the 1974 Act.

## 3. *Inquests*

### (a) **Statutory basis**

81. The law governing Inquests is found in the Coroners Act 1988 and the Coroners Rules 1984. Section 11 of the Act provides that, at the end of an Inquest, a Coroner or jury must complete and sign an inquisition. Pursuant to section 11(5) an inquisition shall set out, so far as such particulars have been proved, who the deceased was and how, when and where the deceased came by his death. Neither the Coroner nor the jury shall express any opinion on any other matters (Rule 36(2)(2) and, in particular “No verdict shall be framed in such a way as to appear to determine any question of (a) criminal liability on the part of a named person, or (b) civil liability.” (Rule 42).

82. Section 16(7) provides that:

“Where a coroner resumes an inquest which has been adjourned in compliance with subsection (1) above – (a) the finding of the inquest as to the cause of death must not be inconsistent with the outcome of the relevant criminal proceedings.”

83. The Coroners and Justice Act 2009 received Royal Assent on 12 November 2009. Part 1 includes new measures concerning Coroners (notably the creation of a new national Coroner's service led by a new chief

Coroner and of a new system of secondary certification of deaths that are not referred to a Coroner) and the remaining provisions concern other criminal justice matters. Part 1 has not yet come into force.

**(b) Relevant case law**

84. In *R(Middleton) v West Somerset Coroner* [2004] 2 AC 182 the House of Lords considered the implications of Article 2 of the Convention on the interpretation of the Act and Rules. It concluded that an investigation should be capable of reaching a conclusion which resolves the central issues of fact in the case. Where a choice between “short-form” verdicts (unlawful killing, open verdict, lawful killing) was not capable of resolving those central issues the Inquest, the House concluded, would not be Article 2 compliant and it may therefore be necessary for the judge or jury to return a narrative verdict, in order to be able to answer not only ‘by what means the deceased came by his death’ but also ‘in what circumstances’.

85. The refusal by a Coroner to leave a particular short-form verdict to a jury is governed by *R v HM Coroner for Exeter, ex parte Palmer* (unreported, 10 December 1997); *R. v Inner South London Coroner, ex parte Douglas-Williams* [1999] 1 All ER; and *R(Bennett) v HM Coroner for Inner South London* [2007] EWCA Civ 617.

86. In *Palmer*, the Court of Appeal stated that the coroner should not leave a verdict to a jury if it falls foul of the test used to determine a submission of ‘no case to answer’ in criminal trials, namely that there is no evidence to support it or if the evidence is so weak, vague or inconsistent with other evidence that, taken at its highest, it is such that a jury properly directed could not properly return that verdict. By contrast, if the strength or weakness of the evidence depends upon the view to be taken of a witness’s reliability, then the verdict should be left to the jury.

87. In *Douglas-Williams* the Court of Appeal clarified the extent of the discretion of a Coroner not to leave to the jury what is, on the evidence, a possible verdict. Lord Woolf MR stated at p. 348:

“If it appears there are circumstances which, in a particular situation, mean in the judgment of the coroner, acting reasonably and fairly, it is not in the interest of justice that a particular verdict should be left to the jury, he need not leave that verdict. He, for example, need not leave all possible verdicts just because there is technically evidence to support them. It is sufficient if he leaves those verdicts which realistically reflect the thrust of the evidence as a whole. To leave all possible verdicts could in some situations merely confuse and overburden the jury and if that is the coroner’s conclusion he cannot be criticised if he does not leave a particular verdict.”

88. The Court of Appeal further clarified this in *Bennett*. Waller LJ, giving the judgment of the court, considered (at paragraph 27 of that judgment) that “there is some (if small) distinction between the position of a coroner deciding what verdict to leave to a jury after hearing all the evidence and that of a judge considering whether to stop a case after the conclusion of the prosecution case” (that is, on a submission of no case to answer). At paragraph 30, he continued:

“coroners should approach their decision as to what verdicts to leave on the basis that facts are for the jury, but they are entitled to consider the question whether it is safe to leave a particular verdict on the evidence to the jury i.e. to consider whether a

verdict, if reached, would be perverse or unsafe and to refuse to leave such a verdict to the jury.”

89. A jury or coroner may only return a verdict of unlawful killing if satisfied beyond reasonable doubt that one or more persons unlawfully killed the deceased (see, *inter alia*, the above cited *Bennett* case and *R(Sharman) v HM Coroner for Inner North London* [2005] EWHC 857 (Admin)).

## COMPLAINTS

90. The applicant complains under Articles 2 and/or 3 and under Article 13 of the Convention about the decision not to prosecute any individuals in relation to her cousin’s death. She makes three arguments.

91. In the first place, she complains that the Code does not comply with the Convention’s procedural guarantees since persons guilty of an offence which violates Articles 2 and/or 3 cannot be charged unless it is likely that a conviction will be secured even if there is sufficient evidence to enable a jury lawfully to convict them. This evidential test is arbitrary, subjective and necessarily based on partial information. Its prohibition on prosecutions of public officials whom a jury could properly convict could lead to the public’s confidence being undermined.

92. Secondly, she complains that the level of scrutiny of the decision not to prosecute violates the procedural aspects of Articles 2 and/or 3: it would be more appropriate for a court rather than a public official to take decisions regarding prosecutions or, alternatively, a prosecutor’s decision should be subject to more intensive review by the courts.

93. Thirdly, she takes issue with the failure to prosecute individual officers (including Commander McDowall, the DSO, the DCI C, the latter two’s tactical advisers (Trojan 80 and 84) and the two SFOs (Charlie 2 and 12). The trial of the OCPM, as a body corporate for a health and safety offence, did not discharge the procedural duty under Articles 2 and/or 3 because it did not require proof of harm, only a risk of harm, and because it did not establish individual liability for her cousin’s death.

## QUESTIONS TO THE PARTIES

Has the State fulfilled its obligation under Article 2 of the Convention to ensure accountability and punishment of State agents or bodies for their fatal shooting of Jean Charles de Menezes on 22 July 2005? In particular, did the failure to pursue criminal and/or disciplinary charges against individual police officers breach Article 2 of the Convention (*Öneryıldız v. Turkey* [GC], no. 48939/99, § 93, ECHR 2004-XII; *Nikolova and Velichkova v. Bulgaria*, no. 7888/03, § 57, 20 December 2007; *Branko Tomašić and Others v. Croatia*, no. 46598/06, § 64, ECHR 2009-... (extracts); *Van Melle v. the Netherlands* (dec.), no. 19221/08, 29 September 2009); and *Kalender v. Turkey*, no. 4314/02, § 52, 15 December 2009)?



In this respect, the Government are requested to submit all decisions of the Independent Police Complaints Commission as regards possible disciplinary charges against relevant officers.