Regulation 28: Prevention of Future Deaths report

Dean Christian JOSEPH (died 05.09.14)

	THIS REPORT IS BEING SENT TO: **1. The Metropolitan Police Service**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 8 September 2014, I commenced an investigation into the death of Dean Christian JOSEPH, aged 40 years. The investigation concluded at the end of the inquest earlier today. The jury made a determination that this was a lawful killing, and added a narrative which I attach. The medical cause of death was: 1a shock and haemorrhage 1b gunshot wound to the back of the left chest.
4	**CIRCUMSTANCES OF THE DEATH** Mr Joseph smashed a window and broke into the home of his former girlfriend. He took her hostage with the aid of a knife. Police were called, and quickly afterwards firearms officers. There was a siege of approximately one and a half hours in total. Mr Joseph remained in the property and refused to release his hostage, while a local police officer tried to negotiate with him from the other side of the broken window.

	When Mr Joseph moved the knife to his hostage's throat, a firearms officer shot him.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. 1. Different officers had a different understanding of whether the armed containment was overt or covert. 2. As you will see from the narrative, the jury noted that there was no guidance from trained hostage negotiators en route, for the local officer who was first on scene. He was attempting to negotiate, though he was untrained as a hostage negotiator. Such guidance might or might not have led to the issuing of an armed challenge. 3. The hostage negotiator co-ordinator felt that it would be useful for the officer in her role to ask when first contacted, "Where does the incident commander want me to meet them?" This is a point which could be included in training. The fact of not asking that question did not appear to have a material impact in this case, but it might in another. 4. My recollection from the evidence I heard, is that the Armed Policing Policy only describes the maximum range of a TASER, not the effective range. The inclusion of the latter might be helpful. 5. The post incident management: • allowed police officers writing their detailed accounts to confer about matters other than simply timings, and • arranged for the display of the control log for them, which included matters outside the personal knowledge of some of the officers. It may seem that this is not a matter for a prevention of future deaths report. However, it will always be the case that we, as a society, try to learn lessons from deaths such as Mr Joseph's, and the learning of any lessons is hampered if the post incident procedure is sub optimal.

	In this case, it was clear to me that the version of events given by police officers was doubted to a degree that would not otherwise have been the case, because of the post incident procedure. • That means that public confidence in the police is eroded, when there may be no substantive reason for this. • It also caused me to exclude some officers from court when other officers were giving evidence which, all other things being equal, I would much have preferred not to do, because it is generally less helpful in ensuring the most meaningful exploration of events.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 October 2015. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] sister of Dean Joseph • [redacted] niece of Dean Joseph I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	**DATE** 12.08.15	**SIGNED BY SENIOR CORONER**