IOPC
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Independent Office for Police Conduct

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Miss Janine Richards
HM Assistant Coroner for County Durham and Darlington
PO Box 282
Bishop Auckland
Co. Durham
DL14 4FY

16 January 2024

Dear Madam,

Re: Inquest of Sarah Holmes

I am writing with regards to the inquest of Sarah Holmes, and thank you for your report under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Thanks also to your office for providing information subsequent to that report.

This is a tragic set of circumstances, and I extend my most sincere condolences to Sarah's family and friends.

1. I am grateful for the opportunity to consider and respond to matters raised in your report which go towards the work of the IOPC.

2. You will know that the IOPC has a significant role to play in the Police Complaints System. And you will know of course that the "police complaints system" is about more than complaints against the Police, also covering "recordable conduct" relating to persons serving with the police and as in this case, Deaths and Serious Injuries which occur following contact with the police.

3. It is the duty of a Chief Officer to refer a Death and Serious Injury (DSI) matter to the IOPC. Having received a referral, we may thereafter determine that it is necessary for the matter to be investigated. Where that arises, we will go on to determine the form which the investigation should take. We may determine that it is appropriate for the investigation to take the form of an investigation by the appropriate authority on its own behalf. This is often referred to as a "local investigation".

4. Where a person conducting a “local investigation” does not identify an indication that a person serving with the police may have a) committed a criminal offence, or b) behaved in a manner which would justify the bringing of disciplinary proceedings, the person investigating shall submit a copy of the investigation report to us.

5. That describes some of the relevant statutory responsibilities in instances such as this. There are of course responsibilities that the we continue to have, such as deciding whether we agree (or not) that the investigation gives an indication of those things that I have detailed in paragraph 4. I am conscious however that your report raises several specific concerns which I should turn to, and that the purpose here is to identify action that can be taken to prevent future deaths.

6. Paragraphs 5 and 7 of your Report involve issues which would appear to relate to the work of the IOPC to which I shall now respond.

Paragraph (5)
“I am concerned that there was a lack of reflection on the part of the Police and there is no formal procedure by which lessons can be learnt from such serious incidents, the professional standards department and IOPC having a limited remit in this regard.”

7. “Learning”, at an individual departmental and Force level, is an important part of the police complaints system. At a departmental and Force level (in fact, at a national level), learning is formally “built into” the complaints system via Section 10 and Paragraph 28A of Schedule 3, Police Reform Act 2002.

8. “Leading Improvement”, of which “learning” is a vital part, is a key area of focus for the IOPC. We are mindful that there are opportunities for learning not just around the behaviour of individuals, but also around issues such as policy, training, practice, leadership and culture.

9. Please consider the following data to be provisional, in the sense that it may yet change, but currently, our data suggests that in the last full reporting year, 1 April 2022 to 31 March 2023, we made 176 organisational learning recommendations. of which 134 were made under Paragraph 28A of the Police Reform Act, where recipients have a legal obligation to respond. 117 were accepted, 9 not accepted and responses are awaited for 8 recommendations.

10. I appreciate that the volume of recommendations may not appear to be overwhelming, but this is generally an area of growth where we tend to be making more recommendations for learning, year on year, certainly in cases which we have not investigated ourselves.

11. It is worth reiterating that our recommendations are not mandatory. They may be refused by the person or organisation to whom they are made. We cannot require any person to accept a learning recommendation. An IOPC learning recommendation should be practicable and meaningful, but the recipient is entitled to hold a differing view as to whether the learning recommendation is both justified, and thereafter practicable and meaningful.

12. While a recipient is not obliged to accept a recommendation, they are legally obliged to respond to a recommendation made under Paragraph 28A (as here), and responses will generally be published. This includes where a recipient does not accept a recommendation, as an explanation as to why it is not accepted is also required.

13. Where a recommendation is made by the IOPC, and rejected by the recipient, it still has importance, as it can contribute to an evidence base for future conversations and future learning opportunities.

14. I think it could be said that there is therefore, a formal procedure by which learning can be identified from such serious events. If a matter is defined as a Death or Serious Injury incident, it will often have to be investigated. The terms of reference for such an investigation will usually include, among other things, whether there is an opportunity for learning. In cases involving the IOPC, as here, we will expressly consider the opportunities for learning.

15. I think this shows that learning is an important area for the IOPC. But I fully accept that our role could be considered to be of "limited remit", in that we do not of course see all cases, and that our recommendations are simply that – recommendations.

16. We did have a statutory and formal involvement in this tragic case, and we would hope that the formal involvement of the Professional Standards Department and the IOPC would help precipitate some reflection. "The system" itself does encourage reflection. I would add here, that this matter was formally investigated by the Professional Standards Department, and the Investigating Officer, the IOPC and thereafter the Appropriate Authority, were all relatively aligned as to the opportunities and need for learning.

17. Regarding any lack of refection in respect of individuals, forgive me but I do not believe it would be appropriate for me to comment further, beyond the findings that we reached on the case. I believe that such matters should better be addressed by the Appropriate Authority and the Police and Crime Commissioner.

Paragraph 7
"I am concerned that IOPC recommendation 3 in this case, namely that the messaging from senior management to the control room was a

negative factor in this case, and should be revisited, was not accepted by senior officers who gave evidence at the Inquest."

18. I understand that the evidence from officers at the Inquest was that they did not agree with our recommendation, asserting that policing decisions were not influenced by SMT messaging, and instead were entirely based upon risk. Our determination was not that policing decisions here were <u>not</u> risk based. But our view is still, without being determinative, that there is evidence which could suggest that the messaging from the SMT did negatively influence the decision making of control room staff.

19. The substance of that messaging features in the FIM's statement, provided during the investigation, and it is difficult to understand why it would feature in that way if the officer did not think it was relevant.

20. We have not taken a definitive position on whether policing decisions in this matter were entirely appropriate and properly reflective of the risk that presented at the time, and so it would not be appropriate for me to do so at this stage. However we are on record as acknowledging that police staff, applying a THRIVE assessment, had tried to deploy Police at 14:37 on 11 July 2022, and that this decision was reversed by the FIM.

21. It is also appropriate to point out that the investigation conducted by the Professional Standards Department did consider that log in particular. It is understandable that each officer must conduct their own assessment of the presenting risk and reach their own conclusions as to the available options. But to be clear, the investigation by the Professional Standards Department expressed the opinion of the Investigating Officer, that there had been sufficient grounds at that time for police officers to enter Ms Holmes' address under Section 17 PACE.

22. We issued some contextual narrative around the recommendations that we made in this case. That narrative said,

    "*The comments made by the FIM and supervisor could suggest that the message passed by the Senior Management Team had negatively influenced the FIM and Supervisor's decision making in respect of this incident…".*

23. Our view was that there was evidence which <u>could suggest</u> that the messaging from the Senior Management Team had negatively influenced the FIM and Supervisor's decision making. We did not definitely conclude that that was the case, as our role is not to be that determinative on matters which would ordinarily be decided by a Court or other tribunal.

24. We did receive a reply from the appropriate authority to our recommendation on 21 April 2023. That reply said,

    "Durham Constabulary acknowledges that messaging from Senior Management has influenced the Force Incident Manager's decision making in this case. This was discussed at a recent development day for Force Incident Managers with a view to clarifying the force position and ensuring that operational decisions are always based on an objective assessment of threat, harm, and risk. The implementation of RCRP/Op Accelerate (see response to 22/172495/001, above) will further clarify the force position and will support staff in making future risk-based decisions".

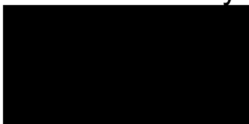
25. We have taken the appropriate authority's acceptance of our recommendations at face value and having been assured of the quick time resolution to our recommendations, that would ordinarily be an end to our involvement in the area of learning in a matter such as this.

26. The evidence provided by the officers at the inquest does not sit entirely squarely with the acceptance of our recommendation by the appropriate authority, and we will be seeking some further clarity from them in this regard.

27. We understand that officers are expected to provide their own accounts and express their own views when giving evidence, and that this will not always align with how those things have been viewed by the appropriate authority. But it is difficult to see how learning can truly be successful if, at the end of the process, it does not encourage introspection and reflection at an individual level.

Please do not hesitate to contact me if there is anything else that we may help with or clarify.

Yours faithfully



Operations Manager
Independent Office for Police Conduct (IOPC)