Neutral Citation Number: [2024] EWHC 556 (Admin)

Case No: AC-2023-LON-003463

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 March 2024

Before :

MRS JUSTICE LANG DBE

- -

Between :

THE KING	**Claimant**
on the application of	
LORNA MCMAHON	
- and -	
INDEPENDENT OFFICE FOR POLICE CONDUCT	**Defendant**
GREATER MANCHESTER POLICE	**Interested Party**

- -
- -

The Claimant appeared in person
Hanne Stevens (instructed by **Independent Office for Police Conduct**) for the **Defendant**
Caroline Jones (instructed by **GMP Legal Services**) for the **Interested Party**

Hearing date: 20 February 2024

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Approved Judgment

Mrs Justice Lang :

1. The Claimant seeks permission to apply for judicial review of the Defendant's ("IOPC") decision, dated 22 September 2023, not to uphold the Claimant's request for a re-investigation of the Interested Party's ("GMP") re-investigation of her complaints, in a report completed in June 2023.

2. The Claimant has also made an application for disclosure.

The IOPC

3. The IOPC was established under Part 2 of the Police Reform Act 2002, replacing the Independent Police Complaints Commission. It is an executive non-departmental public body responsible for overseeing the police complaints system in England and Wales.

4. It is responsible for investigating the most serious matters and allegations against the police and other law enforcement bodies, including deaths and serious injuries following police contact.

5. Its functions also include reviews of the outcome of police investigations into complaints concerning the conduct of police officers, where a complaint is not upheld by the local police force. That is the power which it exercised in this case.

6. Paragraph 25 of Schedule 3 to the Police Reform Act 2002 applies where a complaint has been subjected to an investigation by the appropriate authority (sub-paragraph 25(1)(a)). Sub-paragraph 25(1B) confers on a complainant "the right to apply to the relevant review body for a review of the outcome of the complaint". In this case, the appropriate authority was GMP and the relevant review body was the IOPC.

7. Sub-paragraphs 25(4A) and (4B) provide:

> "(4A) On a review applied for under sub-paragraph (1B), the relevant review body must determine whether the outcome of the complaint is a reasonable and proportionate outcome.
>
> (4B) In making a determination under sub-paragraph (4A), the relevant review body may review the findings of the investigation."

8. By sub-paragraph (4C), if upon an application under sub-paragraph (1B), the Director General of the IOPC finds that the outcome is not a reasonable and proportionate outcome, the Director General may:

> "(a) make the Director General's own findings (in place of, or in addition to, findings of the investigation);
>
> (b) direct that the complaint be re-investigated;
>
> (c) make a recommendation to the appropriate authority in respect of any person serving with the police—

> (i) that the person has a case to answer in respect of misconduct or gross misconduct or has no case to answer in relation to the person's conduct to which the investigation related;
>
> (ii) that the person's performance is, or is not, unsatisfactory;
>
> (iii) that disciplinary proceedings of the form specified in the recommendation are brought against the person in respect of the person's conduct, efficiency or effectiveness to which the investigation related;
>
> (iv) that any disciplinary proceedings brought against that person are modified so as to deal with such aspects of that conduct, efficiency or effectiveness as may be so specified;
>
> (d) make a recommendation under paragraph 28ZA."

9. A review is not a re-investigation. It is an opportunity for an independent review of the way in which the force investigated the complaints, and, if necessary, to take appropriate steps.

10. During a review the IOPC considers the sufficiency of the investigation. This means determining whether the outcome of the complaint is reasonable and proportionate. This includes looking at whether a proportionate investigation was conducted, and sufficient evidence obtained, in accordance with the relevant guidance. The IOPC reviews the outcome and decides whether the conclusions of the local investigation into the complaint were reasonable conclusions on the basis of the evidence which was gathered.

11. The IOPC does not have control over the police handling of a criminal matter. It cannot review the results of a criminal investigation or instruct the police to re-investigate a criminal allegation. However, a person may make a complaint about the conduct of a police officer in connection with a criminal investigation that the police are currently carrying out or have completed. This would not lead to a review of the criminal investigation itself.

History

12. As this is a permission application, not a substantive hearing, I have not set out the lengthy history in full. I have addressed the history of the Claimant's complaints against the IOPC for procedural unfairness and breach of the Equality Act 2010 in a separate section of my judgment. All police officers referred to below are officers of GMP.

13. This claim arises out of the sad and untimely death of Ms Teresa McMahon ("TM"), the Claimant's niece, who died on 3 August 2021 at her home.

14. The police attended the scene on 3 August 2021. On 4 August 2021, the Senior Investigating Officer, DI Gareth Humphreys, made an Initial Special Procedure Investigation report which concluded that there was no positive evidence, information or intelligence to indicate any third-party involvement in a criminal act and no unresolved suspicious circumstances. The working hypothesis was that she had taken her own life by hanging.

15. TM had been in an intermittent relationship with Mr Robert Chalmers ("RC"). She told friends and family that he had assaulted her on several occasions. She reported a history of domestic violence (including broken ribs and fingers) and of controlling and manipulative behaviour to GMP in July 2021. She made a request under Clare's Law (the domestic violence disclosure scheme). She subsequently retracted her complaints against RC and so no action was taken against him by GMP. After TM's death, her neighbour confirmed to police that some weeks previously she had intervened in a row between TM and RC, and asked RC to leave the house.

GMP Complaints CO/01735/21 & CO/00081/22

16. The Claimant made a complaint to GMP about the initial investigation on 7 September 2021: ref. CO/01735/21. In particular, she alleged that DI Humphreys did not carry out an adequate investigation into RC's possible involvement in TM's death.

17. On 12 January 2022, the Claimant made a further complaint: ref. CO/00081/22. She complained about the inadequate police investigation into TM's death and the failure to charge RC for assaults on TM, disclosed by TM in July 2021. She also complained about the officer who was her point of contact (DI Blackwood).

18. Complaints CO/01735/21 and CO/00081/22 were reviewed by DCI Jenkins on 27 September 2022. In regard to the complaints about the investigation into RC's possible involvement in TM's death, he was satisfied that all reasonable lines of enquiry had been completed and there was no evidence of third party involvement or suspicious circumstances. He did not review aspects of these two complaints which had been addressed in CO/00234/22 (a further complaint made by the Claimant).

19. The Claimant applied to the IOPC for a review of DCI Jenkins' report on her complaints. The IOPC's decision was set out in a letter from Ms Claire Avril, Casework Manager, dated 30 June 2023. In her assessment, she found that the allegations about failure to provide Clare's Law disclosure, and that GMP should have charged RC for the assaults which TM reported in July 2021, were the subject of another of the Claimant's complaints (reference CO/0234/22) which had also been considered by the IOPC. Therefore she considered it was appropriate for DCI Jenkins not to include these allegations in his review.

20. Ms Avril went on to consider DCI Jenkins' conclusions in regard to the Claimant's complaint about DI Humphreys' investigation into TM's death and RC's involvement. She concluded that the allegations related to criminal investigations and she advised that it was not within the IOPC's remit to review criminal investigations. She stated that DI Humpheys had adhered to the College of Policing Guidance on 'Practice Advice: Dealing with sudden unexpected death' which was formally approved by the National Police Chief's Council and the Chief Coroner. She

concluded that there was insufficient evidence that any of the officers involved had breached the Standards of Professional Behaviour and she agreed with DCI Jenkins that the actions of the officers were acceptable.

21. Overall, her conclusion was that the service that the Claimant had received was acceptable and the outcome was both reasonable and proportionate. As a result, the Claimant's application for review was not upheld.

GMP complaint CO/00234/22

22. On 5 February 2022, the Claimant made a complaint to the Chief Constable of GMP, which was forwarded to GMP Professional Standards Branch ("PSB") and logged as a complaint on 8 February 2022. The complaint concerned GMP's failure to investigate TM's allegations of assault and domestic violence against RC: complaint reference CO/00234/22. The complaint is summarised at the beginning of the investigation report dated June 2022, at page 66.

23. On 11 February 2022 the complaint was referred from GMP to the IOPC. The Claimant indicated prior to the referral that she was not content with the final heads of complaint as recorded by GMP. On 15 February 2022, the IOPC decided that the complaint would be investigated locally.

24. On 25 February 2022 the Claimant submitted a further complaint about GMP's failure to investigate TM's allegations of assault which was addressed together with the complaint of 8 February 2022.

The first investigation and IOPC review application

25. DC Sample finalised the investigation report on 30 June 2022, and it was communicated to the Claimant on 10 August 2022. The complaint that PSB investigated was that TM's death could have been avoided if police acted differently prior to her death, by investigating her allegations of domestic violence, identifying her as vulnerable, and providing her with Clare's Law disclosure. PSB did not uphold the complaint. The outcome was that the service provided by GMP was acceptable.

26. On 19 August 2022 the Claimant submitted her request to the IOPC for a review of GMP's investigation, over the telephone.

27. On 17 January 2023, the IOPC upheld the Claimant's review application. Ms Avril found that the complaints had not been sufficiently addressed and so the outcome was not reasonable and proportionate. She directed that GMP re-investigate the Claimant's complaint and recommended some lines of enquiry.

The reinvestigation and second IOPC review application

28. GMP's re-investigation report was finalised by the investigating officer ("IO"), DS Hannah Greetham, in June 2023, and was communicated to the Claimant on 17 July 2023. The complaints were summarised as follows:

i) GMP should have investigated domestic abuse allegations against RC both while she was alive and after her death.

ii) GMP should have identified TM as vulnerable.

iii) GMP should have provided TM with Clare's Law disclosure.

iv) TM's death could have been avoided if GMP had acted differently.

29. The terms of reference were set out as follows:

i) To evaluate the initial investigation into domestic abuse allegations made by TM and assess it against the relevant policies, including investigation into any Body Worn Video and what may have happened to that footage.

ii) To evaluate the posthumous investigation into TM's domestic abuse allegations and assess this against the relevant policies.

iii) To specifically assess the decision not to interview RC.

iv) To assess whether TM was vulnerable and whether GMP should have assessed her as such. To evaluate what impact this would have made, if any, to the actions taken by GMP.

v) To assess whether a disclosure should have been made to TM as a result of her Clare's Law application, and if a disclosure had been made, what impact it may have had.

vi) To assess where possible if GMP missed an opportunity to prevent TM's death.

30. The re-investigation report identified some organisational failings and errors on the part of individual officers, but the overall conclusion was that the service was acceptable.

31. The Claimant submitted her request for a review of the re-investigation to the IOPC on 20 July 2023. On 18 August 2023, Mr Neil Evans, Director, Police, Crime, Criminal Justice and Fire at Greater Manchester Combined Authority (GMCA), acting on her behalf, submitted grounds in support of the Claimant's application for review under the following headings:

i) Allegation 1: GMP should have investigated domestic abuse allegations against TM's former partner RC both whilst she was alive, and after her death. She was dissatisfied with both areas of investigation.

ii) Allegation 2: GMP should have identified TM as vulnerable.

iii) Allegation 3: GMP should have provided TM with the 'Clare's Law' disclosure that she applied for.

iv) Allegation 4: TM's death could have been avoided if GMP had acted differently.

32. On 22 September 2023, Ms Rachel Watters, Casework Manager at the IOPC, issued her decision in which she concluded that the outcome of GMP's reinvestigation was reasonable and proportionate and therefore the application for review was not upheld. This is the decision to which this claim relates, and I consider it in more detail below.

Other reports and documents

33. On 22 October 2023, DS Hughes provided a PIP4 Review into the death of TM. The review included an investigation of 28 issues raised by the Claimant. The investigation concluded that TM took her own life by hanging, and there was no evidence of criminality or third-party involvement. DS Hughes set out five recommendations for individual or organisational learning.

34. The PIP4 Review was commissioned at a Gold meeting chaired by Assistant Chief Constable Jackson. At an earlier meeting, on 10 July 2023, between ACC Jackson, the Claimant and Mr Evans, the Claimant alleged that DI Humphreys "deliberately covered up the death of Teresa McMahon in an obvious attempt to protect the credibility of GMP whilst they were under special measures. DI Humphreys deliberately lied in his witness statement and failed to retain vital evidence and exhibits" (Claimant's statement dated 19 February 2024, page 7).

35. The Claimant submitted the following material, in addition to those in the bundle agreed by the other parties:

    i) Two witness statements from RC.

    ii) Witness statement from PC Barnett.

    iii) Result of post mortem examination.

    iv) Letter from Dr Swindles, TM's GP, setting out history of mental health problems, for which she was prescribed medication. Her last consultation was in January 2021 when she complained of upper abdominal pain. An ultrasound was requested, but did not take place prior to her death. She was given Omeprazole for suspected indigestion. No reference to her mood was noted.

    v) Pathologist's report which diagnosed cause of death as 1(a) asphyxia and 1(b) suspension by ligature.

    vi) Domestic homicide review by Salford Community Safety Partnership.

    vii) Letter from Baroness Hughes, Assistant Deputy Mayor for Greater Manchester.

    viii) Photograph of clothes rail.

    ix) Emails from Ms Marcheta Hogan, Senior Police Coroner's Officer, to IOPC.

    x) Text messages from TM to her friend dated 26 May 2021.

    xi) Recording of telephone call between TM and PC Sharrocks on 12 July 2021.

Grounds of challenge

36. The Claimant's principal grounds as pleaded in the claim form issued on 21 November 2023 were (1) illegality; (2) procedural impropriety; and (3) "a ground under the Human Rights Act 1998".

37. In her statement of grounds, the Claimant contended that:

    i) Ms Watters based her decision on inaccurate information from the IO at GMP and without obtaining supporting medical evidence;

    ii) Ms Watters refused the Claimant's requests for reasonable adjustments due to her disability under the Equality Act 2010. She refused to speak to the Claimant on the telephone during her investigations, which was a reasonable adjustment agreed with the IOPC and the previous casework manager, Ms Avril. Staff were also instructed to hang up the telephone whenever the Claimant called.

    iii) Ms Watters and the IO documented inaccurate medical information about TM in an attempt to pervert the course of justice. The IO knowingly gave inaccurate and misleading information to the IOPC. The IOPC documented inaccurate medical information in relation to TM in an attempt to pervert the course of justice.

    iv) At the meeting with ACC Jackson and Mr Evans in July 2023, GMP promised to give the Claimant full disclosure of information in its possession unless the Coroner disagreed. The information was not provided.

38. The Claimant filed Further Grounds, which incorporated a Statement of Facts, on 30 January 2024, in support of her principal grounds.

39. The IOPC filed an Acknowledgment of Service and Summary Grounds on 15 December 2023, and a Response to the Claimant's Further Grounds on 12 February 2024. GMP filed an Acknowledgment of Service and Supporting Information on 14 December 2023, and a letter in response to the Claimant's Further Grounds on 9 February 2024.

40. On 19 February 2024, the Claimant filed a witness statement.

Grounds 1 and 3: Illegality and breach of the HRA 1998

41. The Claimant's overarching criticism was that Ms Watters' findings were mostly opinions, as opposed to facts and she placed undue reliance upon the IO's investigation report which was inaccurate and misleading. She claimed that there was "no credible evidence in the [IOPC] report which suggests the [IOPC] have conducted a fair, independent, non-biased investigation into my request for a review" (Further Grounds, paragraph 5).

42. In my judgment, Ms Watters was entitled and indeed required to assess the IO's investigation report in the light of the material relied upon by the IO. The role of the

IOPC is not to re-investigate the complaint for itself. Rather, it has to consider the investigation carried out by the force, and determine whether the outcome was reasonable and proportionate.

43. In my view, the statutory test in sub-paragraph 25(4A) of Schedule 3 to the Police Reform Act 2022 requires an exercise of judgment on the part of the IOPC, applying very broad criteria. On a claim for judicial review of the IOPC's decision, the Court cannot substitute its views for those of the force investigator or the IOPC reviewer. Generally, the Court will only intervene where the IOPC's decision discloses a public law error e.g. misdirection in law, irrationality, failure to take into account relevant considerations or taking into account irrelevant considerations, bias, and procedural unfairness. The test at permission stage is whether a claimant has established arguable public law errors that have a realistic prospect of success at a substantive hearing. In this case, I have also considered whether there has been an arguable breach of the Human Rights Act 1998.

44. The letter of 18 August 2023 from Mr Evans to the IOPC summarised the Claimant's grounds for a review of GMP's reinvestigation as follows:

> "**Allegation 1: GMP should have investigated domestic abuse allegations against Teresa's former partner Robert Chalmers both whilst she was alive, and after her death. You are dissatisfied with both areas of investigation.**
>
> The investigation report by DS Greetham identifies a number of issues where policy was not followed, which do not require repeating here, but Ms McMahon wishes to emphasise the following.
>
> In the IOPC review report, upholding that request, the reviewer, Clare Avrill states, "Teresa is described by the investigating officer as not engaging with officers, or hesitant to provide further details of the situation, and she informed officers that she did not wish to proceed with any further police action against Mr Chalmers. The reinvestigation could consider what Teresa's motive would be behind this, was she afraid of repercussions, or experiencing coercion and control within her relationship with Mr Chalmers." Miss McMahon asserts that these observations have not been adequately consider in the re-investigation.
>
> Ms Avrill, also stated, "It is of note that Teresa was visited at her home address by PC Keen on 21 July 2021. This is a delay of 9 days, and in my view, this would be a significant time to have passed in regard to an investigation of this nature. The police investigator does not appear to have addressed and provided a meaningful rationale for this delay, and demonstrated if any consideration was made in regard to how this could have impacted Teresa and how she would feel about pursuing this matter." Ms McMahon asserts that whilst a rationale has been provided for the delay, there has been no

consideration of the effect that this delay had on Teresa and how she felt about pursuing the matter. Rather there is a focus on Teresa, failing to attend the appointment.

Ms McMahon has recently been provided with the statement of DI Gareth Humphreys by the coroner (which is enclosed), Mr Humphreys being the senior investigating officer in respect of Teresa's death. She asserts that this statement is littered with inaccuracies, which are contradicted by body-worn video of the scene and of neighbours being spoken to, which she herself has viewed. She also points out that the investigation was reviewed by DCI Gareth Jenkins at her request, who concluded that it was satisfactory. Ms McMahon states that Mr Jenkins did not view body-worn video and thus questions how he could come to such a conclusion when not reviewing all of the evidence.

Given that DS Greetham identified a number of organisational failures or instances of policy not being followed, as well as what is outlined above, Ms McMahon cannot accept that the finding that the service provided was acceptable and thus strongly asserts that the outcome in this respect is neither reasonable or proportionate.

Allegation 2: GMP should have identified Teresa as vulnerable

As well as the paragraphs from the IOPC review referenced above, Ms McMahon also highlights this further paragraph, *"It is of note that Mr Chalmers had a history of offending on PNC, and this intelligence was available to officers. Therefore, what considerations of risk were made in regard Teresa from Mr Chalmers. The reinvestigation could consider if it was an appropriate decision to dismiss this information when all of the information is put into context? Would this be in line with the Domestic Abuse policy for Greater Manchester Police. Additionally, was this in line with the DVDs guidance, and were all the checks that are recommended within the DVDs policy undertaken appropriately."*

Ms McMahon asserts that the investigation report by DS Greetham makes conclusions about this element based on what officers/staff knew at particular times in respect of certain information, as opposed to considering the totality of information in the overall context, as the IOPC pointed out. She also recalls a telephone conversation with Claire Avrill who told her that GMP should have treated Teresa as vulnerable. She is of the view that if it were considered as the IOPC suggested, the service in no way could be described as acceptable and therefore the stated outcome cannot be reasonable or proportionate.

Allegation 3: GMP should have provided Teresa with the 'Clare's Law' disclosure that she applied for.

The findings of DS Greetham are self-explanatory and clearly show that policy, was neither understood or followed. Ms McMahon received a cover letter from the 'appropriate authority' accompanying DS Greetham's report, where there is a reference to the 'myth,' of officers believing that a disclosure cannot be made where a person has left the relationship. Ms McMahon finds the description of this failure as a 'myth,' as both insulting and extremely worrying. She also believes that the policy was understood, but simply not followed.

Ms McMahon is concerned that DS Greetham concludes that the service in this regard was acceptable, as no decision had been made (the 35 days as per policy not having been reached by the time Teresa died). It remains the case that Teresa was provided with inaccurate information throughout, and that learning was identified for at least 2 officers. In these circumstances Ms McMahon simply cannot accept or understand how the service provided can be described as acceptable and thus DS Greetham's finding cannot be described as reasonable and proportionate.

Allegation Four: Teresa's death could have been avoided if GMP had acted differently.

Ms McMahon continues to contend that Teresa's death was as a direct result of domestic abuse inflicted upon and against her by Robert Chalmers. Indeed, she does not believe that Teresa took her own life, rather Robert Chalmers murdered her, which is why she remains determined that a criminal investigation into Teresa's death takes place. At any rate, Ms McMahon believes that if GMP's response to her initial disclosure to them would have been more timely, as their own investigation acknowledges that it should have been, and she was provided with Clare's Law disclosure, she would have had more support and knowledge, which would have prevented her death. Again therefore, she contends that based on the findings within their own investigation report, the service provided by GMP cannot be described as acceptable. This the outcome is not reasonable.

Ms McMahon also points out that in the original compliant outcome, that was subject to an upheld review by the IOPC, it was concluded that the missing body-worn video footage of PC Keen's conversation with Teresa, was attributed to a 'system error.' Following the review GMP advised her that the footage had been corrupted and they were making efforts through a third party to retrieve it. Now, in the most recent outcome, she is advised that the footage was erased as per the system, as it had not been identified as required for evidential retention. She

> believes that these differing explanations are highly suspicious, and that the footage was actually deleted as it would indicate that Teresa did actually want action taking against Robert Chalmers. She also questions why DI Humphreys, as the senior investigating officer, did not secure it given its relevance when it would still have been available, which further influences her overall view."

45. I have carefully considered all the written and oral submissions and evidence filed by the Claimant in support of her claim for judicial review. It is not possible to refer to every point, but where I have not specifically referred to a point made by the Claimant, it does not mean that I have overlooked it. I have identified the following main issues:

    i) Exclusion of the Claimant's allegations in respect of the investigation by DI Humphreys.

    ii) Initial investigation of domestic abuse allegations.

    iii) GMP should have identified TM as vulnerable.

    iv) Missing body worn video footage ("BWV footage") of PC Keen's interview with TM on 21 July 2021.

    v) GMP should have provided TM with Clare's Law disclosure.

    vi) Posthumous investigation into domestic abuse allegations.

    vii) TM's death could have been avoided if GMP had acted differently.

(i) Exclusion of the Claimant's allegations in respect of the investigation by DI Humphreys

46. The allegations against DI Humphreys are set out above in Allegations (1) and (4) in the letter of 18 August 2023.

47. In the IOPC decision Ms Watters responded to these allegations at paragraph 7 as follows:

> "7. You also raised the following concerns which I am unable to consider:
>
> a) DI Humphreys, the Senior Investigating Officer (SIO) in respect of Teresa's death, did not secure the BWV footage recorded by PC Keen as part of his investigation.
>
> b) The statement of DI Humphreys is littered with inaccuracies which are contradicted by BWV footage of the scene and of neighbours being spoken to.

> c) The review of DI Humphreys' investigation, conducted by DCI Jenkins, did not consider the BWV footage referred to in (b).
>
> The investigation conducted by DI Humphreys is outside of the remit of this review and as such I will not consider these matters. Please note that should you wish to raise any new complaints, which have not already been recorded and considered by GMP, you should contact GMP directly."

48. In her Further Grounds, the Claimant reiterated her allegations about the sufficiency of DI Humphreys' investigation into TM's death, including RC's involvement and whether it was murder rather than suicide; as well as the adequacy of DCI Jenkins' investigation. She challenged Ms Watters' decision that these matters were outside the scope of the complaint. See in particular, paragraphs 1, 2, 3, 4, 14, 20, 21, 22, 23, 28, 29, 30, 69 - 78 of the Further Grounds.

49. This claim for judicial review only challenges the IOPC decision of 22 September 2023, which was only reviewing the complaints in GMP complaint CO/00234/22. As set out at Judgment [28], those complaints were that:

    i) GMP should have investigated TM's domestic abuse allegations against RC, both while she was alive and after her death.

    ii) GMP should have identified TM as vulnerable.

    iii) GMP should have provided TM with Clare's Law disclosure.

    iv) TM's death could have been avoided if GMP had acted differently.

50. The complaint about the adequacy of the investigation that DI Humphreys undertook into the cause of TM's death on 3 August 2021, and whether RC was involved in her death, was not part of GMP complaint CO/00234/22. As the IOPC decision correctly stated, at paragraph 7, it was outside the remit of that review.

51. Those issues were considered in GMP complaints CO/1735/21 and CO/00081/22, which were reviewed by DCI Jenkins. He found as follows:

> "I have reviewed the investigation carried out by DI Humphreys into the death of Teresa McMahon. As the Senior Investigating Officer (SIO) for a Special Procedure Investigation (SPI), there is an expectation that the officer will take command and control of the investigation including their attendance at any relevant scenes. The primary role of the SIO is to identify if there are any suspicious circumstances or evidence of third-party involvement in the death being investigated. If the SIO is satisfied that there is no evidence of this, their role is then to support the coroner in understanding how the relevant person died. I am aware that you have been granted interested party status for the inquest into Teresa's death. As a result, you have been provided access to the

material generated within the investigation, including the statement of DI Humphreys. His statement outlines the investigation into the death, therefore I do not intend to detail all aspects of the investigation.

In terms of the home address where Teresa was found deceased. There was no evidence to support that there had been a struggle, disturbance or that the property had been tidied to conceal that a crime had been committed. There is no evidence to support that anybody entered the address prior to Teresa being found. Other than the evidence that Robert Chalmer entered on his own when he attended with his father and then again when he re-entered with Teresa's father a short time later. This is when Teresa was discovered deceased. An examination of Teresa's body did not identify any injuries that could not be accounted for. The scene examination did not identify any evidence of third-party involvement. I am aware that you were concerned that a forensic examination did not take place. There is no expectation for the SIO to request a forensic examination of the scene unless there is evidence that a crime may have been committed, this forms part of the training provided to SIO's. Having considered the investigation I am satisfied that a Crime Scene Investigator would not have advanced this investigation and it was appropriate for the SIO not to request their attendance.

Teresa's ex-partner Robert Chalmers was present when Teresa was found deceased. There is an omission within his statement that he had entered the address alone prior to entering with Teresa's father. The SIO has considered the relevance of this omission. There is evidence from Robert Chalmers's father that Robert entered the address shortly before alone. The short period between these two entries and likely time of death support that this omission had no bearing on her death. DI Humphreys did consider if Robert was involved in the death, but there is no evidence of this. Through the forensic examination of Teresa's mobile phone and corroboration of data obtained from the network provider. The SIO was able to evidence communication between Teresa and Robert shortly before her death, but that they were in separate locations. The phone work corroborated Roberts account regarding his movement leading up to Teresa being found. I support the SIO's assessment that Robert Chalmers was not involved in the death of Teresa.

In conclusion, I am satisfied that the SIO has undertaken a thorough and professional investigation. All reasonable lines of enquiry have been identified and completed. I have not identified any further actions that should be completed. I support the SIO's conclusion that there is no evidence of third-

> party involvement or suspicious circumstances surrounding the death of Teresa."

52. The Claimant exercised her right to apply to the IOPC for a review of DCI Jenkins' investigation. In her decision dated 30 June 2023, Ms Avril identified the points raised by the Claimant as follows:

    a) You believe that DI Humphreys carried out an inadequate investigation into TM's death.

    b) You state that DI Humphreys failed to take the allegations, made by TM's neighbour, seriously.

    c) You believe that DI Humphreys also failed to review the serious allegations and photographs submitted by RC's ex-girlfriend, Stacey Farrell.

    d) You state that you want DCI Jenkins to reopen the case and carry out a criminal investigation into TM's death.

    e) You state that DI Humphreys had been made aware of the domestic violence that was ongoing prior to TM's death.

    f) You have concerns as you believe that RC was the last person to have seen TM alive.

53. Ms Avril advised that a review of the adequacy of the criminal investigation carried out by GMP was outside of the IOPC's remit. In my view, this advice was correct, for the reasons set out in Judgment [11]. She considered the conduct issues raised and concluded that DI Humphreys had adhered to the College of Policing Guidance on 'Practice Advice: Dealing with sudden unexpected death' which was formally approved by the National Police Chief's Council and the Chief Coroner. She concluded that there was insufficient evidence that any of the officers involved had breached the Standards of Professional Behaviour and she agreed with DCI Jenkins that the actions of the officers were acceptable. Overall, her conclusion was that the service she had received was acceptable and the outcome was both reasonable and proportionate. As a result, the Claimant's application for review was not upheld.

54. The Claimant did not agree with the decision of 30 June 2023, and made a complaint against Ms Avril. In her email of 30 June 2023, the Claimant accused her of colluding with GMP and covering up police failings. She alleged that the Director General of the IOPC (Mr Tom Whiting) was putting the public at risk by allowing such corruption and collusion. Her email was copied to the Chief Constable of GMP, among others.

55. The decision of 30 June 2023 has not been set aside by the IOPC and should be treated as valid. The Claimant has not mounted any legal challenge against it by way of judicial review, and it is too late to do so now.

56. For these reasons, I consider that the Claimant's grounds on this issue are unarguable and have no realistic prospect of success.

57. However, I do not consider that this leaves significant unanswered concerns in the complaints procedure. Following the Claimant's meeting with ACC Jackson and Mr Evans on 10 July 2023, DS Hughes was tasked with undertaking a PIP4 review which investigated *inter alia* the Claimant's allegations of inadequate investigation by DI Humphreys and the concern that TM did not take her own life but was murdered by RC. DS Hughes considered the BWV footage of the investigation following TM's death, which was an issue ruled out of scope by Ms Watters in the decision of 22 September 2023, at paragraph 7(c), and which has also been raised by the Claimant in support of her application for disclosure in this claim for judicial review, which I deal with below.

58. DS Hughes considered 28 issues raised by the Claimant. He concluded, at page 232:

> "In conclusion, I believe that all available evidence suggests that Teresa tragically took her own life by hanging with a ligature. In contrast, that there is no evidence of criminality or third-party involvement. In my view, a reasonable and proportionate investigation has taken place into the circumstances of her death lead by DI Humphreys. Subsequent reviews, including my own have not led to the discovery of any evidence that supports a hypothesis of homicide."

59. Finally, the inquest into the death of TM has been adjourned pending the outcome of this claim for judicial review. The inquest will consider all relevant evidence in order to determine the cause of TM's death.

(ii) Initial investigation of domestic abuse allegations

60. This matter was raised in Allegation 1 in the letter of 18 August 2023.

61. Ms Watters's findings and conclusions were as follows:

> "**GMP's initial response to Teresa's disclosure that she had been subjected to domestic abuse.**
>
> 13. In my opinion, the available evidence indicates that there were organisational failings in the time it took for GMP to respond to Teresa's allegation of domestic abuse and how quickly she was seen by police. I will explain my reasoning.
>
> 14. In her report, the IO provided an accurate summary of Incident Log 591-120721 which records the steps taken after Teresa made her application for a DVDS disclosure on 12 July 2021. This log shows that it was nine days, from the submission of the DVDS application, until Teresa was visited by PC Keen on 21 July 2021. The IO acknowledged that this delay was too long and conducted a detailed investigation into why this delay occurred, including obtaining a quality assessment of the incident logs related to the case, from the Force Contact Centre (FCC) and obtaining a review of the

contact that Teresa had with GMP, from DCI Lindsay Booth of the Public Protection Governance Unit (PPGU).

15. In my opinion, the available evidence supports the IO's conclusion that the initial assessment of the DVDS application, undertaken by Civ. 71020 Mottram, and the action taken by them, to book an appointment for Teresa to attend the police station the following day, was appropriate. I am of this opinion because I have reviewed Incident Log 591-120721, GMP's Incident Response Policy and the FCC Quality Assessment of the incident logs. Civ. Mottram assessed the initial DVDS application as a Grade 2 priority. This was in keeping with the force policy at the time, as confirmed within the FCC quality assessment document.

16. PS 17117 Potts then reviewed the incident log and changed the risk level to low, suitable for a domestic abuse appointment. The IO acknowledged that this decision was premature. This conclusion is supported by the FCC quality assessment document, which indicated that further background checks should have been conducted. The IO identified individual learning for PS Potts in respect of this matter. In my view, this is an appropriate action to take to improve performance, however as PS Potts is now retired this learning will not be delivered.

17. PC 08292 Sharrocks telephoned Teresa on 12 July 2021 and booked her an appointment to attend Swinton Police Station the following day. I am of the view that the available evidence supports the IO's conclusion that this course of action was appropriate. I am of this opinion because I have listened to the telephone conversation, between Teresa and PC Sharrocks, and in my view, the information provided by Teresa meets the criteria for a low priority incident, as defined within GMP's Incident Response Policy.

18. Unfortunately, after booking Teresa's appointment, PC Sharrocks failed to take the required administrative action, which meant that when the appointment was subsequently cancelled, this was not picked up and no attempts were made to rearrange the appointment. The FCC quality assessment of the incident logs indicated that the case sat in the wrong queue, without anyone having ownership of the case, until it was picked up again on 19 July 2021. The case was then allocated to PC Keen on 21 July 2021. The IO identified individual learning for PC Sharrocks in respect of this matter. In my view, this is an appropriate action to take to improve performance, however the IO confirmed that this learning would not be delivered because PC Sharrocks was on leave, pending retirement.

19. In my view, it is unclear whether Teresa was aware that her appointment at Swinton Police Station had been cancelled. The IO indicated that there is some evidence which suggests that Teresa did not attend the appointment, firstly because no information was added to the incident log to indicate that she had attended, and secondly, because one of Teresa's friends had made the comment 'Teresa called up about a Clare's Law disclosure but didn't go'. However, in my view, there is insufficient information to conclude, with certainty, whether Teresa had made the decision not to attend the appointment, or whether she had been informed that the appointment had been cancelled.

20. In your application for review, you indicated that the IO had failed to consider the effect that the delay in police visiting Teresa had on how she felt about pursuing her allegation of domestic abuse against Mr Chalmers. In my view, the IO has acknowledged this impact. I am of this view because, in her report, the IO stated, 'it is accepted that the delay in seeing Teresa, whilst not necessarily being the cause of her change of heart, would have done nothing to inspire her with confidence that her concerns were being taken seriously'.

21. Overall, I am of the view that the available evidence supports the IO's conclusion that the issues which delayed Teresa being seen by police were caused by human error. In my view, the individual learning identified by the IO was appropriate to address these matters. It is my opinion that, whilst unfortunate, the delay did not prevent GMP from investigating Teresa's allegation of domestic abuse. I am of this view because the case was allocated to PC Keen, on 21 July 2021, who progressed the investigation.

Investigation conducted by PC Keen.

22. Having compared the actions taken by PC Keen, with the guidance outlined in GMP's Domestic Abuse Policy, the IO concluded that she could not identify any failures except for PC Keen not marking her BWV footage as evidential. In my opinion, this conclusion is supported by the available evidence. I will explain my reasoning.

23. The available evidence confirms that PC Keen visited Teresa's home on 21 July 2021. At 12:29pm, on 21 July 2021, PC Keen created a Domestic Abuse Record (known as the 'DAB'), in accordance with GMP's Domestic Abuse Policy. The DAB includes a detailed overview of the information provided, by Teresa, to PC Keen. The IO has provided a summary of this information in her report, and I will not repeat it here. The DAB indicates that Teresa did not wish to provide much detail, with regards to the assault that she had alleged.

She did not want the crime to be progressed and did not support a prosecution of Mr Chalmers. Teresa confirmed that the relationship with Mr Chalmers had ended, and that she had no intention of getting back into a relationship with him.

24. At the same meeting, PC Keen completed the DASH Risk Assessment with Teresa. DASH stands for 'Domestic Abuse, Stalking / Harassment, Honour-Based Abuse' and is a national risk identification tool which can be used by professionals to identify and assess the risk to victims of domestic abuse. Teresa declined to answer the DASH questions, however, as per the requirements of the GMP Domestic Abuse Policy, PC Keen included available information on the DASH form and made a professional judgement as to the level of risk, which she viewed to be medium. According to the GMP Domestic Abuse Policy, a medium risk is given where there are indicating factors of serious harm, but this is not thought to be imminent unless there is a change in circumstances.

25. In my view, the available evidence indicates that PC Keen made attempts to explore, with Teresa, the reasons for her reluctance to provide further details of her relationship with Mr Chalmers and her rationale for not wanting to pursue police action against him. I am of this view because Teresa's responses are recorded in the DAB and in the DASH risk assessment, in which PC Keen noted 'Victim would not answer the DASH questions stating that she does not want anything to come back from her report. She initially wanted a Claire Law (sic) and was not disclosing any offences. She would not go into detail about what had happened during their relationship'.

26. Following her visit to Teresa, PC Keen submitted a crime report, CRI/06FF/17809/21 for a section 39 common assault, with Teresa as the victim and Mr Chalmers as the suspect, a summary of which is included in the IO's report. PC Keen recommended that the crime was sent for closure, because 'the victim does not support and does not wish to pursue this further'. PC Keen also noted that there were no further potential lines of enquiry to follow. On 26 July 2021, Inspector 14451 Struttman confirmed that the crime could be closed, with no further action, pending any further information coming to light. During the investigation of your complaint, the crime report (CRI/06FF/17809/21) and DAB, submitted by PC Keen, were reviewed by DCI Booth, who did not identify any concerns regarding the action taken.

Action taken by PC Doherty.

27. The GMP Domestic Abuse Policy indicates that the District Safeguarding Team triage all medium risk domestic abuse

> events. In Teresa's case, PC 11343 Doherty undertook this triage.
>
> 28. On 22 July 2021, PC Doherty conducted the triage on the DAB completed by PC Keen. The actions taken by PC Doherty were reviewed by DCI Booth, who concluded that she had conducted a thorough risk assessment.
>
> 29. Having reviewed the information recorded by PC Doherty on the DAB, I am of the view that her actions were in line with the requirements of the GMP Domestic Abuse Policy. I am of this view because the policy specifies actions that should be taken by the person conducting the triage and, in my view, where applicable, these actions were carried out by PC Doherty. As per the policy, the notes recorded by PC Doherty on the DAB log, indicate that she attempted to contact Teresa within 72 hours of conducting the triage. This is supported by the telephone audit, obtained by the IO, which confirmed that PC Doherty attempted to telephone Teresa on the 22 and 29 July 2021 and the 5 August 2021. Unfortunately, these calls went unanswered.
>
> 30. The GMP Domestic Abuse Policy requires the person conducting the triage to conduct a number of checks, on police systems. In my view, the notes recorded by PC Doherty, on the DAB, indicate that these checks were made.
>
> 31. The policy also requires the person conducting the triage to identify suitable support agencies to signpost victims to. The IO asked PC Doherty to confirm what she would have done had she been successful in her attempts to contact Teresa. In her account dated 22 February 2023, PC Doherty confirmed that she would have discussed safeguarding, offered Teresa support services (which she named), and asked if Teresa had any mental health issues. PC Doherty also confirmed that she would have further discussed the DVDS application, this matter will be addressed in my assessment of allegation three."

62. In her Further Grounds, the Claimant referred to paragraph 26 of the IOPC decision above, stating that it was misleading to say that PC Keen submitted her crime report following her visit to TM's home, as the report was not submitted until after TM's death in September 2021, as evidenced by the fact that the crime reference number was the same as the one given to her by DI Humphreys in November 2021.

63. According to the IO's report, at page 111, PC Keen submitted this crime report in July 2021, and it was authorised for closure by Inspector Struttman. The IOPC submits, and I accept, that this matter was only raised by the Claimant in the Further Grounds and did not form part of the IOPC's review. Accordingly, it cannot be relied upon in this claim.

64. The IO's report investigated a message that TM sent to RC's ex-partner which stated "I put in the Claire's Law request and the police rang me straight away to say he's extremely dangerous". The IO found that there was no evidence of any such telephone call from the police. In the Further Grounds at paragraph 32, the Claimant alleges that she was informed by Ms Avril that PC Keen had advised TM that RC was a dangerous man. PC Keen denied this allegation (IO's report pages 109 -110). However, this matter was not raised in the review application to the IOPC and therefore not addressed in the IOPC's decision.

65. In my judgment, Ms Watters' findings and conclusions do not disclose any arguable public law error.

(iii) GMP should have assessed TM as vulnerable

66. The Claimant raised this issue in Allegation 2 in the letter of 18 August 2023.

67. In the IOPC decision, Ms Watters made findings and reached conclusions as follows:

> "50. In conducting my assessment of allegation two, I have firstly considered whether Teresa provided any information, either via the DVDS disclosure application, or in person when she spoke to PC Sharrocks, to indicate that she should be identified as 'vulnerable'. In doing so, I have referred to the definition of 'vulnerable' taken from the THRIVE risk assessment guidance, which explains that 'a person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves, or others, from harm or exploitation'.
>
> 51. In respect of the information provided in the DVDS application, there is insufficient evidence to suggest that Teresa met the criteria for being identified as vulnerable.
>
> 52. In respect of the conversation between PC Sharrocks and Teresa, I have reviewed Incident Log 591-120721, which shows that at 09:33am on 12 July 2021, having spoken to Teresa, PC Sharrocks completed a THRIVE assessment. The IO provided information on the THRIVE assessment process in the form of a GMP training presentation. The person making the assessment is required to identify a risk level, provide their rationale for this, and identify whether the person in question is vulnerable. Incident Log 591-120721 shows that PC Sharrocks identified a low risk level for Teresa. His rationale for this decision was that Mr Chalmers was now Teresa's ex-partner and they did not live together. PC Sharrocks also noted that Teresa had 'no known vulnerability'. Having listened to the call between PC Sharrocks and Teresa, I can't identify any information that would suggest that Teresa met the criteria for being identified as vulnerable, as described in paragraph 50 of this letter. For these reasons, I am of the view that it was

reasonable for PC Sharrocks to indicate that Teresa had no known vulnerability.

53. In respect of PC Keen, the information recorded in the DAB record, Crime report CRI/06FF/17809/21 and DASH risk assessment does not include reference to Teresa having disclosed any vulnerability factors. PC Keen has specifically recorded that no issues relating to alcohol or mental health were disclosed by Teresa when she visited her. As such, I am of the view that PC Keen was not in possession of information which indicated that Teresa was vulnerable.

54. In addition, the IO concluded that despite PC Keen having no reason to doubt that Teresa's relationship with Mr Chalmers was over, she addressed the risk that they may rekindle their relationship by offering safeguarding advice and discussing longer term safeguarding measures. In my view this conclusion is supported by the DAB completed by PC Keen, which indicates that she provided advice to Teresa, in respect of what action to take if Mr Chalmers came to her home, discussed options for longer term safeguarding actions and provided details of agencies that Teresa could contact for support.

55. I have also considered whether GMP was in possession of any information about Teresa, prior to her DVDS application on 12 July 2021, which could have led them to identify Teresa as vulnerable, as per the definition outlined in paragraph 50 of this letter.

56. The IO determined that GMP were unaware of Teresa's mental health, previous attempt to take her own life, medication and alcohol consumption. In my view, this determination is supported by the available evidence. I am of this view because the IO has confirmed that prior to the incidents to which this complaint relates, there was no information held on GMP systems, relating to Teresa, except for two unrelated historical matters.

57. In the additional information you submitted in support of your application for review, you indicated that the IO's conclusions, about whether GMP should have identified Teresa as vulnerable, were based on what officers and staff knew at particular times, in respect of certain information. In your view, the IO should have considered the totality of the information in the overall context. Taking into account the available evidence, including what was known to individual officers, and the information available to GMP as a whole, I am of the view that the IO has provided a reasonable rationale as to why Teresa was not identified, by GMP, as vulnerable.

> 58. The IO has determined that the service provided by GMP was acceptable. From the evidence and explanations I have reviewed, I am in agreement. I conclude that the outcome of this complaint was reasonable and proportionate."

68. In her Claim Form, the Claimant alleges that (1) the IOPC and the IO documented inaccurate medical information in relation to TM in order to pervert the course of justice; and (2) the IOPC failed to obtain supporting medical evidence.

69. In her Further Grounds, the Claimant raises the following issues:

i) Paragraphs 37 – 40:

> "In the iopc report dated 22nd of September 2023: Ms Watters acknowledged that she had listened to the telephone conversation on the 12th July 2021, between PC Sharrocks and Teresa McMahon . Ms Watters believed that the information provided by Teresa meets the criteria for a low priority incident.
>
> I have listened to the recorded telephone conversation which was disclosed to me by the coroner on the 30th November 2023. Within Ms Watters review , she has failed to acknowledge a serious allegation made by Teresa in this call : broken rib and fingers . This allegation should have been logged as ABH, not common assault. Ms Watters has also failed to acknowledge the obvious fear which can be heard in Teresa's voice , specifically at the prospect of officers attending her home. It is clear in this recorded telephone conversation that Teresa was concerned about repercussions should her ex partner become aware that the police had attended her home. It is also clear that Teresa appears vulnerable and frightened.
>
> PC Sharrocks picked up on Teresa's concerns, and gave her an option to attend a police station. After listening to this call it is clear that the police should have sent a response unit to Teresa's home the same day . I am of this belief because the officer was aware of the suspect's previous charges and convictions . The officer was also aware that Teresa was frightened and fearful of her ex partner . Teresa told the officer that Rob had also attacked and strangled another ex partner , and was constantly attempting to get back into Teresa's life. Within this call Pc Sharracks does not appear to have any genuine concerns for Teresa's safety. I therefore believe that the following decision made by Rachel Watters: " in my view, the information provided by Teresa meets the criteria for a low priority incident, as defined within Gmp's incident response policy" , to be unlawful . The evidence which I will rely upon is the recorded telephone conversation between Teresa and PC Sharracks on the 12th July 2021.

> In her report Ms Watters repeated and relied upon information given to her by the IO . This is in relation to a section 39 common assault. However the allegation which Teresa made on the 12th July 2021 to PC Sharracks in the recorded call , which Ms Watters has listened to, was that her ex partner had broken her rib and fingers . Therefore this allegation should have been logged as ABH not common assault . If this had been the case then the 6 months time limit would not have applied."

ii) Paragraphs 58-59:

> "Rachel Watters believes that there was no evidence in the telephone call which suggests that Teresa was vulnerable. She also believes that the officers could not have known if Teresa was vulnerable as Teresa did not disclose she was vulnerable. I agree with the first iopc case manager , it appears that the police are victim blaming Teresa for not disclosing her vulnerability. The definition of vulnerable is not isolated to the references made in Ms Watters review. A person can suddenly become vulnerable at any time depending on their circumstances . The definition of vulnerable can also mean a person who is exposed to the possibility of being attacked or harmed, either physically or emotionally.
> I therefore believe that it is paramount that the deciding Judge in this case listens to the three minute recorded telephone conversation, between Tereasa and PC Sharrocks on the 12th of July 2021, before coming to a decision whether Teresa was or was not, vulnerable at that time."

70. In my view, the IO and Ms Watters accurately summarised the medical evidence that was available to officers in July 2021, when it is alleged that an assessment of vulnerability should have been made.

71. The IO made the following findings at page 116:

> "25. Medical evidence obtained for coronial investigation
>
> DS Manning reviewed the medical evidence as part of her overall review into allegations of controlling and coercive behaviour (further discussed below).
>
> I have had sight of the pathology report of Teresa's autopsy from the Coroner's office. There is nothing to suggest Teresa was the victim of any serious domestic violence in the report. With regards to broken bones, no gross deformity was noted. DS Manning also reviewed a letter from Teresa's GP which was found to sum up Teresa's medical history. Teresa tested positive for Covid on 26/07/2021. She had a long history of mental health problems and had received support. She took an overdose in 2004. Alcohol problems are referred to in 2007 and 2010. She was recorded as drinking 20 units a week in 2020.

> She was assessed by psychology in 2010 but did not engage. Panic attacks are mentioned several times, the last time being November 2020. She was taking Sertraline and Amitriptyline. There was no mention of any broken bones or domestic abuse in the GP report."

72. The IO made further findings at page 127:

> "PC Keen has recorded a crime appropriately and set a medium risk DASH which appears appropriate to the circumstances provided by Theresa.
>
> Medium is described as there are indicating factors of serious harm, but this is not thought to be imminent unless there is a change in circumstances.
>
> It is difficult to fully assess the risk when the DASH questions were refused. Theresa had documented suicidal thought in her diary on the 23rd June yet made no disclosure of this to PC Keen on the 21st July. This is not intended as a criticism of Teresa.
>
> The medical evidence gathered within the coronial investigation relating to Teresa's mental health, previous suicide attempt, medication and her alcohol consumption was not information known to GMP when Teresa was alive. Officers would have been totally reliant on what she told them. Looking at PC Keen's updates Teresa did not disclose this information which is highly likely to affect a risk assessment."

73. The account of TM's medical history, which was included in the IO's report and Ms Watters' decision, was derived from the GP's letter to the Coroner, dated 18 August 2021. The pathologist's report confirmed the presence of her prescription medication and alcohol (130 mg). Thus, it came from reliable sources and it was clearly relevant information. The IOPC was not under any obligation to obtain further medical evidence.

74. Ms Watters listened to the recording of the telephone call from PC Sharrocks to TM on 12 July 2021, in which TM stated "He's also broke my fingers, broke my ribs, just generally battered me and attacked me loads." The IO transcribed part of the recording, including the passage quoted above, and inserted it into her report (page 104). TM's broken ribs and fingers were referred to in PC Keen's crime report, which was quoted in the IO's report (pages 110 and 111). At paragraph 42 of her decision, Ms Watters referred to DS Manning's investigation of TM's allegations of assault, including her report of an injury to her ribs. Therefore it is inconceivable that Ms Watters was not aware of TM's account of her broken ribs, or that she failed to take it into account in making her decision.

75. The IO's report included a passage from PC Keen's Crime Report which states:

> "She was asked about the comments she made in relation to Robert breaking her ribs and fingers again she would not go into too much detail only saying that he has grabbed hold of her hand squeezing her fingers and has grabbed her around the waist squeezing her ribs causing them to break. Teresa states that her ribs were broken in October 2020 and her fingers were broken around 6 weeks ago. However, Teresa has not sought any medical attention to either assault, so it is unclear if her fingers and ribs were actually broken.
>
> Teresa states that her ribs hurt for some time after and she was left with some reddening on her stomach and has full use of her fingers.
>
> Teresa stated that she does not want to support a prosecution or provide many details because she does not want this to be brought up and feels like it might cause further issues.
>
> She confirmed that hers and Robert's relationship has ended, and she has no intention in getting back in a relationship with him."

76. It seems that the lack of evidence of the broken fingers/ribs was the reason why the police were considering a charge against RC of common assault, not assault occasioning actual bodily harm. The IO noted DS Manning's view to this effect, at page 120. I do not consider that the GP's report amounts to evidence of broken ribs, and in any event, it was not available at that time.

77. In my view, when considering the issue of vulnerability, Ms Watters acted appropriately in applying the definition of "vulnerable" from the THRIVE risk assessment guidance which explains that "a person is vulnerable if as a result of their situation or circumstances they are unable to take care of or protect themselves or others from harm or exploitation" (paragraph 50).

78. In completing the THRIVE risk assessment, PC Sharrocks identified a low risk level for TM on the basis that she was no longer in a relationship with him and they were not living together. The IO considered the risk assessment was reasonable. Ms Watters found that the information provided by TM met the criteria for a low priority incident, as defined within GMP's Incident Response Policy. Overall, Ms Watters concluded that it was reasonable for PC Sharrocks to indicate that TM had no known vulnerability, on the basis of the information before him. The Claimant placed particular emphasis on the telephone call recording, but in my view, Ms Watters was entitled to assess the call in the way in which she did. I have had the benefit of listening to the recording, as well as reading extracts from the transcript.

79. Furthermore, at the interview with TM on 21 July 2021, PC Keen addressed the risk that TM's relationship with RC might be rekindled, and offered advice in respect of what action to take if RC came to her home, discussed options for longer term safeguarding actions, and provided details of agencies that TM could contact for support.

80. Whilst I accept that the Claimant disagrees with Ms Watters' conclusions, in my judgment, Ms Watters' assessment of this part of the complaint does not disclose any public law error.

81. For the reasons I have set out above, I do not consider that the Claimant's grounds are arguable and have a realistic prospect of success.

(iv) Missing BWV footage of PC Keen's interview with TM on 21 July 2021

82. This issue was raised in Allegation 4 in the letter of 18 August 2023, and in the Claimant's Further Grounds at paragraphs 43-48 and 53-57.

83. Ms Watters' findings and conclusions on this issue were as follows:

> "**Deletion of PC Keen's BWV footage**.
>
> 32. It was confirmed, in the original complaint investigation (conducted by DC Richard Sample), that the Body Worn Video (BWV) footage recorded by PC Keen, when she attended Teresa's home on 21 July 2021, was no longer available. The explanation of why the BWV was not available was limited, stating simply that this was due to a 'system fault'. In your complaint, you raised concerns about why the BWV footage could not be obtained. In order to address these concerns, the IO conducted a thorough investigation into why the BWV is no longer available. The IO found no evidence that PC Keen had wilfully sought to hide the BWV footage she had recorded and concluded that the deletion of the BWV footage resulted from an administrative error.
>
> 33. In my opinion, this conclusion is supported by the available evidence. I am of this opinion for the following reasons. Firstly, PC Keen acknowledged, in her statement dated 10 May 2023, that she incorrectly flagged the BWV footage, which meant that it had not been saved.
>
> 34. Secondly, PC Mark Jones, from the Digital Futures Team, completed an audit of the BWV footage related to the case, and confirmed that whilst the relevant footage had been flagged with a 'Domestic Abuse' marker, on 20 August 2021, an evidential retention maker was not applied. This meant that the BWV footage automatically deleted after 28 days. PC Jones confirmed that the footage had self-deleted, it was not manually deleted, and it was not possible, for any officer, to delete BWV footage from the system.
>
> 35. Thirdly, PC Jones confirmed that it was PC Keen who added the 'Domestic Abuse' maker to the footage on 20 August 2021. The IO concluded that this would indicate that PC Keen's intention, after learning of Teresa's death, was to ensure

> that the footage was retained. In my view this is a logical conclusion.
>
> 36. In the additional information you provided in support of your application for review, it was stated that you had been given inconsistent information about the availability of PC Keen's BWV footage. In my view, the IO has conducted thorough enquiries to investigate why the BWV footage was not available, and to provide reassurance that it is not possible for an officer to delete footage from the BWV system.
>
> 37. In my opinion, appropriate actions have been taken to address the error made by PC Keen. PC Keen's account indicates that she acknowledged her error and was now aware of the correct process for marking BWV footage so that it is saved. In addition, the IO confirmed that changes have been made to the BWV system to ensure that footage marked as 'Domestic Abuse', and with no other markers added, would now be retained for six years. This was confirmed by PC Mark Jones, from the Digital Futures Team in an email dated 23 May 2023. The IO also acknowledged that the original complaint investigation, conducted by DC Sample, could have probed further into why the BWV was no longer available and offered an apology for any confusion and distress this had caused to you."

84. The Claimant queries the plausibility of PC Keen adding a domestic abuse marker to the footage on 20 August 2021 after becoming aware of TM's death because of the delay of 17 days from when PC Keen knew that TM had died on 3 August 2021. I do not consider that the delay casts doubt on the veracity of the information.

85. The main thrust of the Claimant's allegation was that the differing explanations for the missing BWV footage were highly suspicious. The Claimant suggested that the footage was deleted because it indicated that TM did want action to be taken against RC. In the light of Ms Watters' detailed and convincing explanation of the reasons for the missing footage, I do not consider that this ground of challenge is arguable nor that it has any prospect of success.

(v) GMP should have provided TM with Clare's Law disclosure

86. This issue was raised in Allegation 3 in the letter of 18 August 2023, and in the Claimant's Further Grounds at paragraphs 60 – 66.

87. Ms Watters' finding and conclusions on this issue were as follows:

> "**Information provided to Teresa by PC Keen**.
>
> 62. In my opinion, the available evidence indicates that Teresa was provided with inaccurate information about her eligibility for a DVDS disclosure by PC Keen. I am of this opinion

because it is clear, from the DAB and DASH Risk Assessment form, that PC Keen advised Teresa that she would not be entitled to a DVDS disclosure because she was no longer in a relationship with Mr Chalmers. In her statement dated 10 May 2023, PC Keen acknowledged this error and indicated that she had since discovered that a DVDS disclosure can be provided to individuals who are in a relationship and those who are not in a relationship.

63. However, in my view, PC Keen's error did not impact on whether the DVDS disclosure was made to Teresa. I am of this view for two reasons, firstly, because it was not PC Keen's role to make a decision on the DVDS disclosure and secondly, because the decision on whether the disclosure would be made was outstanding at the time of Teresa's death.

Actions taken by PC Doherty.

64. In her account dated 22 February 2023, PC Doherty confirmed that she would have been responsible for deciding whether Teresa would be provided with a DVDS disclosure. In her report, the IO referred to the DAB completed by PC Keen, which was then added to by PC Doherty. The DAB records the actions taken by PC Doherty, in respect of Teresa's request for a DVDS disclosure. The IO has provided a summary of the document in her report, and I will not repeat it here.

65. As part of her investigation, the IO asked DCI Booth to review the DAB and provide her comments on the actions taken. DCI Booth acknowledged that the process followed by PC Doherty would not be advocated within the new DVDS Policy. The IO indicated that this is because, in the circumstances in this case, the decision about whether or not to make a DVDS disclosure should be made by a sergeant. However, DCI Booth confirmed that the process followed by PC Doherty was being replicated across several districts at the time, and that the policy in place was unclear as to the action that should be taken. I also note that PC Doherty confirmed, in an email to the IO on 23 February 2023, that had she been unsure about whether or not the DVDS disclosure should be given, when she had come to make that decision, she would have spoken to her sergeant or inspector.

66. In her report, the IO noted that PC Doherty recorded the following, on the DAB, in respect of a DVDS disclosure; 'N/A-no longer in a relationship. Teresa has been informed that she does not meet the criteria for disclosure.' The IO asked PC Doherty why she had included this information on the DAB. PC Doherty confirmed, in her account dated 22 February 2023, that she had done so in reference to the fact that PC Keen had informed Teresa that she was not eligible for the disclosure.

The IO indicated that PC Doherty should have amended this information, if she believed it to be incorrect, and in my view, this is a reasonable conclusion. As such, the IO identified individual learning, in respect of this matter, for both PC Keen and PC Doherty.

67. In her report, the IO confirmed that, at the time of Teresa's death, it had not been decided whether a DVDS disclosure would be made, or what any disclosure would have included. The DVDS policy allows for up to 35 days to make a final decision and at the time of Teresa's death, the log remained open, and PC Doherty was making active attempts to contact Teresa. In my view, this conclusion is supported by the available evidence. I am of this view because I have read the DVDS policy and reviewed the DAB which was being updated by PC Doherty. PC Doherty recorded, on the DAB, that she had attempted to contact Teresa on 22 July 2021, 29 July 2021 and 5 August 2021 and unfortunately did not get an answer. This is supported by the telephone audit data obtained by the IO. Each of these calls lasted a very short time indicating that PC Doherty did not speak to Teresa.

Issues with the DVDS policy in place in July 2021.

68. In her statement, DCI Booth provided a detailed overview of the process followed in this case, in respect of the DVDS disclosure. The IO has included the relevant points in her report, and I will not repeat DCI Booth's assessment here, suffice to say that a number of issues were identified, in respect of the DVDS policy in place at the time of Teresa's death. The IO confirmed that this policy was updated, in October 2022, to include learning from Domestic Homicide Reviews, HM Coroner reviews and IOPC recommendations.

Consideration of whether a DVDS disclosure would have been made to Teresa.

69. Despite the decision not having been finalised, in respect of the DVDS disclosure, at the time of Teresa's death, the IO conducted enquiries in an attempt to determine whether it is likely that, on the basis of the available information, Teresa would have been provided with a DVDS disclosure. The IO obtained opinions on this matter from Sgt Walsh, DI Poole and DCI Booth.

70. The IO concluded that Sgt Walsh and DI Poole were of the opinion that a DVDS disclosure was not likely to have been made to Teresa. In my view, this conclusion is supported by the email that Sgt Walsh sent to the Serious Case Review on 21 June 2022, in which he stated, 'the circumstances would not have warranted a DVDS being issued due to TM stating that

she was not longer in a relationship with RC and had no plans to resume the relationship.' It is also supported by comments made by DI Poole, in the PIP2 document, which have been redacted in the IO's report for confidentiality reasons.

71. In her statement, DCI Booth provided a thorough assessment of whether Teresa could or should have been provided with a DVDS disclosure. In her report, the IO has included a summary of the information provided by DCI Booth, and I will not repeat it here. However, DCI Booth concluded that, had she personally been asked to make the DVDS disclosure, she would have insisted on further contact with Teresa. As discussed in paragraph 67 of this letter, PC Doherty was still attempting to contact Teresa, at the time of her death. In her account, PC Doherty stated that, had she been able to contact Teresa, and there had been any suggestion that she may get back into a relationship with Mr Chalmers, she would have further discussed the DVDS disclosure.

72. During her investigation, the IO identified individual learning for PC Keen and PC Doherty in respect of their understanding of the DVDS scheme. However, she explained that she was satisfied that this individual learning would be addressed by wider measures being implemented by GMP. I contacted the IO to seek confirmation of what action had been taken and she confirmed that the DVDS policy had been updated and launched and that training, to enhance the knowledge and skills of practitioners when making decisions about the DVDS, has been delivered to the safeguarding teams (of which PC Doherty is a member).

73. In addition, the IO identified, during her investigation, that the misconception, that separation is a barrier to disclosure for the DVDS scheme, may be more widely held within GMP. In order to get the message out to frontline officers, the IO submitted organisational learning, via GMP's internal organisational learning team. As a result of this process, this learning was raised and submitted 'on Chief Constables Orders' which reaches every police officer and staff member in GMP.

74. The IO also confirmed that the individual learning for both PC Keen and PC Doherty will be re-enforced, following the outcome of this review, when they will both receive a full copy of the IO's report along with the new DVDS policy.

75. In the additional information you provided, in support of your application for review, you indicated that you did not understand the IO's determination that the service provided in respect of complaint three was acceptable, given that the IO had concluded that the DVDS disclosure policy was neither

understood nor followed and that learning had been identified for at least two officers.

76. I contacted the IO to seek clarification on this matter and she explained that whilst she had identified learning, she did not uncover anything, during her investigation, which showed that a DVDS disclosure should have been made. The IO confirmed that the final decision on whether to provide the disclosure had not been made at the time of Teresa's death and she therefore concluded that the service was acceptable.

77. In my opinion, there is insufficient evidence to conclude that GMP should have made a DVDS disclosure to Teresa and failed to do so. I am of this view firstly because a final decision had not been made, in respect of the disclosure, at the time of Teresa's death and PC Doherty was making active attempts to contact Teresa and discuss her application. Secondly, in my view, the available evidence indicates that GMP had insufficient information, at the time of Teresa's death, to determine that the criteria for making the DVDS disclosure had been met.

78. In my opinion, the IO has conducted a thorough investigation into this complaint. She has identified both individual learning and organisational learning in respect of this matter and taken steps to ensure that this learning is delivered in the most effective way. In my view, these are appropriate actions to take to improve performance. I conclude that the outcome of this complaint was reasonable and proportionate.

79. In the additional information you provided, in support of your application for review, you raised a concern about the IO's reference to the 'myth' of officers believing that a DVDS disclosure cannot be made when a person has left a relationship. You indicated that you found this term insulting and worrying. Whilst conducting my assessment, I reviewed a set of presentation slides provided by the IO. The slides were for a presentation given by the Serious Case Review Unit, of the Investigation and Safeguarding Review Team at GMP. One of the aims of this presentation was to outline recommendations from Domestic Homicide Reviews which related to DVDS disclosures. In the presentation slides, reference is made to a number of 'myths', i.e., misconceptions which officers may hold, in respect of the guidance around DVDS disclosures. In my view, it is likely that the IO used the word 'myth' in her report, for this reason, and in order to explain that the need to address this misconception had been identified and addressed by GMP. I hope that this explanation will provide you with some reassurance in respect of why this word was used."

88. The Claimant questioned why the IO found that the service provided was acceptable, given that the policy on disclosure was not understood by PC Keen. The Claimant submitted that the findings and conclusions set out by the IO were wrong, and therefore it was unlawful and irrational for the IOPC to accept them.

89. In my judgment, the Claimant's submissions are unarguable and has no prospect of success.

90. There were clear findings of fact that it was not PC Keen's role to decide whether TM was eligible for disclosure under the terms of the Clare's Law scheme; further information had to be obtained from TM before a decision on eligibility could be made; PC Doherty was making active but unsuccessful attempts to contact TM; and the 35 day time period permitted for making a decision under the terms of the scheme had not yet expired.

91. Under the terms of GMP DVDS Policy 2012, information about a person's previous convictions is confidential and can only be disclosed if:

    i) it is reasonable to conclude that disclosure is necessary to protect the person at risk from being the victim of a crime;

    ii) there is a pressing need for such disclosure; and

    iii) the interference with the right to confidentiality is necessary and proportionate for the prevention of crime.

92. According to DCI Booth, further information would have been needed to justify disclosure as necessary and proportionate, in circumstances where TM had stated that the relationship had ended and she had no intention of resuming it, and there was no reason for further contact with RC, such as shared responsibility for children. The view of DS Walsh and DI Poole was that disclosure was not likely to have been made in TM's circumstances.

93. Ms Watters' opinion (at paragraph 77) was that there was insufficient evidence to conclude that GMP should have made a disclosure to TM, and that it wrongly failed to do so. In my view, that was a lawful exercise of her judgment in the light of the evidence before her.

94. In Allegation 3 in the letter of 18 August 2023, the Claimant alleged that the reference in the covering letter from the 'appropriate authority' accompanying DS Greetham's report, to the 'myth,' of officers believing that a disclosure cannot be made where a person has left the relationship, was "both insulting and extremely worrying". In my view, the explanation given by Ms Watters for the use of the word "myth", in paragraph 79 above, does not demonstrate any arguable error on her part.

(vi) Posthumous investigation into domestic abuse allegations

95. Allegation 1 in the letter of 18 August 2023 stated that the Claimant was dissatisfied with the investigation of TM's domestic abuse allegations against RC after her death.

96. Ms Watters made findings and reached conclusions as follows:

"38. In respect of the investigation into domestic abuse allegations, made by you after Teresa's death, the IO determined, having assessed the completed enquiries documented by DS Manning and DI Poole, that the conclusions reached were reasonable. This included the decision not to interview Mr Chalmers.

39. In my opinion, the available evidence supports the IO's determination. I will explain my reasoning.

40. The IO indicated, in her report, that after Teresa's death you made a report of controlling or coercive behaviour (CCB) against Mr Chalmers with Teresa as the victim. You also requested that GMP investigate evidence of the assaults that had been disclosed by Teresa, as well as those that had been referred to in text messages after Teresa's death. DS 13033 Manning and DI 17803 Poole conducted this investigation.

41. In my opinion, it is clear from the PIP2 Action and Review document, and Crime Report CRI/06FF/0030288/21, that a wide range of investigative actions were completed by DS Manning. In her report, the IO listed a number of these actions, and I will not repeat them here. However, I would note that a large amount of information has been included in the PIP2 document, indicating that DS Manning took numerous accounts and statements, reviewed Teresa's notebooks and communications between herself and her family and friends and reviewed medical evidence.

42. In respect of the allegations of assault, DS Manning concluded that the only evidence she had found of domestic abuse was a S39 assault, for which the six-month statute limit of prosecution had expired. In my view, DS Manning provided a detailed rationale explaining how she reached this determination. DS Manning indicated that whilst she had considered interviewing Mr Chalmers about both this matter, and Teresa's report that he had hurt her ribs in October of 2020, there was no necessity to do so because Mr Chalmers could not be prosecuted. As SIO of the investigation, DI Poole updated the PIP2 document on 27 June 2022. Having reviewed the actions taken and conclusions reached by DS Manning, DI Poole concluded that 'there are no grounds to speak to Mr Chalmers as a suspect for assault which was unsupported when Teresa was alive and has passed the statute of limitations for any prosecution'.

43. In respect of the allegation of CCB, DS Manning concluded that she had found no evidence of coercive or controlling behaviour towards Teresa by Mr Chalmers. In my opinion, a detailed rationale was provided, by DS Manning, as to how she reached this determination. DS Manning's conclusion was

> supported by DI Poole, who indicated, in her update to the PIP2 document on 27 June 2022 'based on all of the information that I have read, seen and experienced first-hand there is not enough evidence to corroborate coercive controlling behaviour by Rob Chalmers to Teresa McMahon'. DI Poole concluded that there was no necessity to speak to Mr Chalmers about the allegation of CCB as this had not been substantiated, despite best efforts, and confirmed her agreement that the crime should be closed.
>
> 44. Having reviewed the investigation log, DCI Booth concluded that DS Manning and DI Poole had conducted a thorough investigation and stated that she concurred, based on DS Manning and DI Poole's assessment, that there was insufficient evidence of CCB.
>
> 45. The IO concluded that the service, provided by GMP, in respect of allegation one, was acceptable. In your application for review, you questioned why the IO had come to this determination when she had identified a number of organisational failings, and instances of policy not being followed, in respect of allegation one.
>
> 46. I contacted the IO to seek clarification on this matter and she explained that whilst she had identified unacceptable delays in the police attending Teresa's home, she did not believe that these delays impacted on the outcome, and they did not form the basis of your complaint. The IO indicated that your complaint was that GMP did not investigate the allegation of domestic abuse, made by Teresa before her death, or the allegations of domestic abuse, including CCB, made by you after Teresa's death. Having conducted her investigation, the IO concluded that GMP did sufficiently investigate both matters which led her to determine that the service provided was acceptable.
>
> 47. In my opinion, the available evidence supports the IO's determination that GMP conducted investigations into both Teresa's initial allegation of domestic abuse, and the allegations made by you after Teresa's death. Further, I am of the view that the IO has gone to considerable lengths to highlight the failings that she has identified in this case and to thoroughly investigate them. The IO identified individual learning where appropriate and sought reassurances that the necessary changes have been made to processes and systems, to prevent similar issues occurring in the future. As such, I conclude that the outcome of this complaint was reasonable and proportionate."

97. In her Further Grounds, at paragraph 50, the Claimant criticised the decision that there was insufficient evidence of controlling, coercive behaviour, on the basis that it was contrary to the information given by TM to PC Sharrocks in the telephone

conversation on 12 July 2021, when she described RC as a manipulative controlling bully.

98. The Claimant also claimed, at paragraph 52, that the decision not to formally interview RC was irrational and wrong, for reasons which relate to DI Humphreys' alleged state of knowledge and responsibilities. It is clear from the IO report and the IOPC decision that the investigation into domestic abuse was undertaken by officers other than DI Humphreys, namely DS Manning and DI Poole.

99. Whilst I acknowledge the Claimant's disagreement with the IOPC decision, Ms Watters was tasked with assessing the IO report and making a judgment as to whether the outcome of the complaint was reasonable and proportionate. In my view, Ms Watters' decision does not disclose any arguable public law error.

(vi) Theresa's death could have been avoided if GMP acted differently

100. This issue is raised in Allegation 4 and in the Claimant's Further Grounds, at paragraph 68, where she refers to the information given by TM to PC Sharrocks.

101. In her decision, Ms Watters made findings and reached conclusions as follows:

> "82. Having completed her investigation, the IO indicated that she did not find that there were any indicators or signs of Teresa's state of mind that GMP missed or failed to address, consequently, she did not identify any opportunities missed by GMP in preventing Teresa's death. In my opinion, this conclusion is supported by the available evidence.
>
> 83. I am of this view because, as outlined in my assessment of allegation two, it is my opinion that GMP were not in possession of information, whether directly reported to them by Teresa, or in respect of records held about her on GMP systems, to know that, at the time of their interaction with her, Teresa may have been experiencing suicidal thoughts. In my view, the available evidence suggests that the officers who interacted with Teresa considered her circumstances and made appropriate determinations as to the risks that she faced in respect of her allegations of domestic abuse. In my opinion, the records made by PC Keen, after visiting Teresa, suggest that appropriate safeguarding information was provided and the details of support organisations that Teresa could contact were offered. PC Keen has specifically recorded, on the DAB log, that Teresa did not have mental health issues. PC Doherty's account, and the records made on the DAB, indicate to me that, had she spoken with Teresa, she would have asked about Teresa's mental health. Sadly, PC Doherty's attempts to contact Teresa were not successful.
>
> 84. I am of the view that the available evidence supports the IO's conclusion that the service provided by GMP was

acceptable and the outcome to this complaint was reasonable and proportionate."

102. In my judgment, Ms Watters' findings and conclusions do not disclose any arguable public law error.

Human Rights Act 1998

103. The Claimant's claim under the Human Rights Act 1998 has never been particularised. I have been unable to identify any arguable breach of the Human Rights Act 1998 in the Claimant's grounds of challenge.

Ground 2: Procedural impropriety and breach of the Equality Act 2010

104. The Claimant submitted that:

i) the IOPC's treatment of her was procedurally improper and unfair; and

ii) reasonable adjustments for her disabilities were not made, contrary to the Equality Act 2010.

105. The Claimant has disabilities, namely, a heart condition which is exacerbated by stress, and arthritis which affects her ability to type and write. She prefers to communicate orally. She informed IOPC of her disabilities and requested "reasonable adjustments" to be made, pursuant to the Equality Act 2010.

106. Her specific complaints were as follows:

i) IOPC initially claimed that her request for a second review had been made out of time, but later accepted that it was in time after the Senior Police Coroner's Officer intervened on her behalf.

ii) Ms Watters refused to speak to the Claimant on the telephone during the investigation, unlike Ms Avril who communicated with her by telephone during the first review.

iii) Ms Watters refused to accept the Claimant's evidence in support of her complaints against DI Humphreys.

iv) Staff were also instructed to hang up the telephone whenever the Claimant called.

v) She was not assisted to make her second application for a review over the telephone, although she had done so when she made her first application for a review.

vi) The IOPC advised her to communicate by post.

vii) The IOPC blocked her emails.

107. The IOPC submitted that it was entitled to apply its 'Managing unacceptable service user contact policy' to the Claimant because of her unreasonable persistent contact and demands. The policy provides, so far as is material:

> "**Our service standards**
>
> …
>
> We also have a responsibility to provide a safe working environment for our colleagues, so we deliver a fair service for all. On the rare occasion that we believe the way a person is communicating prevents us from doing this, we may decide to restrict the nature or frequency of their contact.
>
> **Meeting the needs of service users and colleagues**
>
> We will always consider how to adjust our service to meet the needs of the people who use our service. However, our colleagues deserve to work without receiving abuse or other unacceptable contact, and we will support our colleagues to manage these difficult situations effectively.
>
> We will make reasonable adjustments (relating to a protected characteristic [Footnote 1 – Equality Act 2010]), for example provide communications in large text format for someone who is visually impaired, or support people to make complaints over the phone in the way we deliver our services. We may still consider it appropriate to restrict contact with people who have a reasonable adjustment in place. This will be a last resort and will depend on all the circumstances of the case.
>
> …
>
> **Defining unacceptable contact**
>
> Contact (by any form of communication) is unacceptable if it is:
>
> - aggressive or abusive, or
> - unreasonably persistent, or
> - an unreasonable demand
>
> **and** could cause our colleagues to feel harassed, distressed, threatened or afraid, or reduce our ability to provide our services to any service user, or meet our statutory obligations.
>
> …
>
> **> Unreasonably persistent contact**

We recognise that some people might be unwilling to accept a decision or action we have taken, or that there are some things we simply cannot do.

However, we may consider contact to be unreasonably persistent where we have already fully advised the service user of the decision, explained the decision to them if needed and they continue to contact us to challenge the decision. If this leads to someone making unwarranted allegations against our colleagues, it will not be tolerated.

> Unreasonable demands

Each case will be assessed independently. However, it is likely that the following types of demand will be considered unreasonable:

- timescale demands (other than those we work towards)
- demands for a specific colleague or team to carry out a task
- demands made to more than one IOPC team or colleague (i.e., sending the same request to difference colleagues)
- making repeated or multiple demands which are substantially the same
- demands for things we cannot do, whether for practical or legal reasons.
- unreasonable escalation of complaints

Unreasonable amounts of contact may also amount to an unreasonable demand. This includes inundating colleagues with information or repetitive communications, content which is difficult to read or understand (subject to specific needs or adjustments), or material which is not directly relevant to our work.

Managing unacceptable contact

We will do all we can to resolve an issue while abiding by our Service Standards, before the putting a restriction in place. We will not remove a person's access to our colleagues without good reason and it will only be a last resort.

To manage a person's contact, we may decide to restrict the nature or frequency of contact in the following ways:

- terminate phone calls (if the caller is being abusive to a colleague for example)
- restrict times, days or durations of permitted contact (for example, if there is excessive and repetitive contact)

> - allocate reasonable times to respond (if there is excessive and repetitive contact for example, which impacts our ability to respond to other service users)
> - assign a single point of contact to the person (for example, if a person attempts to contact various members of colleague with the same issue)
> - limit the ways in which a person may contact us (for example, if a person is abusive or harassing colleague, or making excessive contact via email/phone)
> - read but not respond to communications (for example, if there is excessive and repetitive contact and the matter has already been addressed)
> - report unacceptable contact to the police (for example, if contact is abusive/threatening)
>
> We will always try to work with people to understand their needs and how they can be met. We will be transparent and inform the person before deciding to put a restriction in place due to unacceptable contact.
>
> "We will always attempt to warn a service user that we consider their contact unacceptable before making a restriction decision. …"

108. The IOPC submitted that it was receiving a large number of emails and telephone calls from the Claimant.

109. The Claimant was frequently emailing Mr Tom Whiting, the IOPC's Acting Director General which was inappropriate. She was warned, both verbally and in writing, to refrain from doing so. The Claimant continued to contact Mr Whiting, and therefore a contact restriction was put in place, on 25 July 2023, to prevent the Claimant from emailing the IOPC.

110. During the same period, the IOPC considered that the Claimant's calls were excessive and particularly challenging, therefore her telephone contact was restricted to one call per week from 25 July 2023. All telephone contact had to go through her named contact, Mr Lucas Crossley, including any contact with other members of IOPC staff.

111. There were numerous communications between the parties, each complaining about the other's conduct. I set out below the key decision letters sent by the IOPC.

112. On 24 July 2023, Mr Jonathan Manning, Customer Contact Manager, wrote to the Claimant as follows:

> "…..
>
> I have previously explained that Lucas will remain your nominated individual in the Customer Contact Centre (CCC) at this time; I will not discuss this point further.
>
> …..

> My previous correspondence in relation to you submitting further reasons for your review in writing apply.
>
> Finally, as we have asked that you do not copy other departments or individuals within the organisation into your correspondence, and you continue to do so, we are now taking the necessary steps to restrict your contact with us by email. This is not something that we wanted to do. However, we have warned you multiple times regarding this matter, yet the issue persists. The option of sending correspondence by post will still be available to you.
>
> Moreover, as we have dealt with an unreasonable volume of calls from you of late, we are also looking at restricting your calls to us to only once a week. This decision will be communicated to you by Lucas in due course."

113. On 25 July 2023, Mr Crossley wrote to the Claimant as follows:

> "I am emailing you today as your Nominated Individual (NI) regarding your recent contact with the IOPC.
>
> I have issued you with a number of warnings relating to your contact with the IOPC; specifically your continued correspondence sent directly to our Interim Director General Tom Whiting. I advised you to only contact the IOPC using this email address (enquiries@policeconduct.gov.uk) via email on 18 and 20 July 2023, as well as on the telephone on 20 July 2023. Further warnings of a similar nature were issued by the IOPC Complaints and Feedback department and by my manager, Jonathan Manning; both of these were also issued in writing via email. Despite this, you have not adhered to these warnings and you have chosen to continue to circumvent the usual contact methods and email Tom Whiting directly. As you have ignored all warnings you have been given, we have no choice but to restrict your email contact with the IOPC. You will no longer be able to contact the IOPC via email as your email address is now blocked; any additional email addresses you use to contact us will also be blocked. The system will still be open to you via online form and by post.
>
> Additionally, due to the excessive amount of time you have spent telephoning the IOPC in recent weeks, we have taken the decision to also restrict your telephone contact; you call the IOPC once a week only. I will continue as your NI and will speak to you on this one occasion should you require to phone the IOPC on that particular week. Furthermore any request to speak to any other department within the IPC will need to come through me exclusively on your allocated contact day. Please note that if you phone us more than once a week the call will be terminated and we will look to restrict you further.

> Please be advised that this was not a step we wanted to take, but due to your excessive recent contact, it was necessary to take this course of action."

114. When the Claimant's second application for review was allocated, she was sent an introductory letter by post from Ms Watters, dated 7 August 2023. Ms Watters included her name and the postal address, but not her email address or phone number due to the contact restrictions in place. Ms Watters was not permitted to have direct email or telephone contact with the Claimant. These restrictions were not in place when the first review application was made.

115. The Claimant had a reasonable adjustment in place, to allow her to submit her review application by telephone. She made her first review application by telephone on 19 August 2022. It was very lengthy.

116. On 20 July 2023, she was permitted to make her second review application by telephone, but the call was terminated by Mr Crossley part way through. Mr Crossley gave his account of what happened in an email of the same date:

> "…. I phoned you earlier to take your review request over the telephone. I advised beforehand that the call would be transcribed so I needed the information to be succinct and related only to your review request. The call did not go as planned so I eventually terminated as I would not have been able to get the call transcribed as it was and it did not relate to your review. I stated that I would phone you to attempt to take your review request again tomorrow. However, since our phone call, you have twice confirmed your request for review in writing, in emails at 12.40 and 12.56; therefore I will not be calling you to take a further telephone review request ….."

117. In the Claimant's email of 20 July 2023 to Mr Whiting, she made a complaint about Mr Crossley stating "Lucas from the contact centre has called me to take my review over the phone. However when he became aware I have just emailed yourself regarding my concerns about my complaint not being handle *[sic]*, he threatened me with a warning and hung up the phone …".

118. The Claimant made a further complaint about Mr Crossley on 21 July 2023, stating:

> "Lucas has lied and decided an email complaint sent by my son on my behalf whilst he was with me is my review. Unless I say this is my review it is not my review. I have a serious heart condition and I believe Lucas is deliberately causing me harm by shouting over me causing me severe stress and anxiety. He is aware of my heart condition and that I am grieving…."

Conclusions

119. The existence of such a detailed policy indicates that the IOPC has previously experienced difficulties in managing the demands of complainants, and balancing the

competing needs of staff and members of the public. I consider it was reasonable for IOPC to adopt this policy. In my judgment, based on the evidence before me, the IOPC applied its policy lawfully in this case. As the policy states, such restrictions are only imposed on "rare" occasions, and as "a last resort" in the case of persons who have reasonable adjustments in place. I doubt that the decision was made lightly; Mr Crossley confirmed that "this was not a step we wanted to take".

120. I do not consider that the restrictions imposed resulted in procedural unfairness and prejudice to the Claimant which give rise to an arguable claim for judicial review.

121. By the time the restrictions were imposed in July 2023, the Claimant was already very familiar with the evidence and issues, following the two local force investigations and the first IOPC review, during which she had raised her concerns. At the second review, Ms Watters was tasked with reviewing the IO's re-investigation report and evidence, in accordance with the statutory criteria; she was not conducting a re-investigation herself. Once the Claimant had lodged her grounds in support of her application for a review, regular and frequent contact by email or telephone with Ms Watters or other IOPC staff would not have been appropriate or necessary. Channels of communication – post and restricted telephone calls - remained open to her.

122. Following the Claimant's request for a reasonable adjustment, her grounds in support of her first review application were taken over the telephone, by a member of IOPC staff, instead of in writing. The transcript (pages 77- 87) indicates that the Claimant gave a lengthy narrative which the member of staff said was "going a little bit off tangent" at times. At the second review, the IOPC again agreed to take her grounds in support of her application over the telephone. However, Mr Crossley failed to do so successfully at the first attempt. Mr Crossley and the Claimant have given different accounts of what took place. However, I accept that Mr Crossley did offer to try again and so did not refuse to make the reasonable adjustment. The Claimant decided not to take up this offer, presumably because she felt that a telephone call with Mr Crossley was not going to be the most effective way of communicating her grounds. Instead she obtained assistance from Mr Evans, who wrote a letter on her behalf to the IOPC, on 18 August 2023, setting out the grounds in support of her application for review: see Judgment [44]. The letter of 18 August 2023 was detailed, well-ordered, cogent, and clear (more so than the grounds given by telephone for the first review). So in my view, the Claimant's case was not prejudiced by the initial failed attempt to take her account over the telephone.

123. Turning to the other points raised by the Claimant, the IOPC eventually accepted that the application was made in time, and so this issue has become academic. For the reasons explained under Ground 1 above, Ms Watters was entitled to find that the Claimant's further evidence/allegations against DI Humphreys were outside the scope of this complaint.

124. In conclusion, I consider that Claimant's grounds of procedural impropriety and failure to make reasonable adjustments under the Equality Act 2010 are not arguable and do not have a realistic prospect of success, for the reasons set out above.

Disclosure

125. The general rules governing the disclosure of documents in civil claims do not apply to judicial review claims. Therefore the Claimant's initial application in the claim form for disclosure of all the evidence and witness statements in relation to the death of TM was not an appropriate application in a claim for judicial review.

126. Documents are disclosed by defendants pursuant to their duty of candour which requires relevant information to be placed before the court. However, in this case disclosure was constrained by the pending inquest, in accordance with standard practice.

127. A claimant may also apply for an order for disclosure of specific documents, as the Claimant has done in this case. On 28 December 2023, the Claimant filed an application notice for disclosure which was sealed by the court on 29 December 2023. The application was for:

    i) BWV footage when police officers attended at Teresa's home, on 3 August 2021, to investigate her death;

    ii) a recording of a telephone conversation between PC Sharrocks and TM on 12 July 2021, following on from her online application for disclosure under Clare's Law.

128. On 15 January 2024, Swift J. ordered that the application for disclosure made on 28 December 2023, and the application for permission to apply for judicial review, were to be determined at a hearing on 20 February 2024.

129. In preparation for that hearing, Swift J. ordered that the Claimant file and serve a document setting out her grounds of challenge to the IOPC decision on 22 September 2023, by 30 January 2024. The Defendant and Interested Party were ordered to file and serve their responses by 13 February 2024. The purpose of this order was to ensure that the Claimant's case was clearly understood by the Court and the other parties, and that the other parties would have a fair opportunity to respond to it.

130. On 19 February 2024, the day before the hearing, the Claimant filed and served a lengthy witness statement, without permission. It included a request for further disclosure. I allowed the Claimant to rely on the witness statement at the hearing, because she is a litigant in person, but I refused to allow her to pursue her request for disclosure as she had not made a formal application for disclosure and this request had been made far too late for the other parties to consider it. At the very latest, it should have been made when the Claimant filed her further submissions on 30 January 2024.

131. At the pre-inquest review on 30 November 2023, the Coroner directed GMP to disclose to him the recording of the telephone conversation between TM and PC Sharrocks and all BWV footage. He also directed that this material would be disclosed to the family which includes the Claimant (see paragraphs 3.2.1, 3.3 and section 4 of the Directions).

132. However, by paragraph 4.2 of the directions, the BWV footage and any other material disclosed under the directions must not be disclosed to any other court, organisation

or person, particularly in relation to the pending judicial review proceedings, unless there is an order of the court addressed to HM Area Coroner to release them for disclosure. The order required the Claimant to sign an undertaking to comply with the non-disclosure order in paragraph 4.2.

133. The recording of the telephone conversation between PC Sharrocks and TM has been disclosed to the Claimant pursuant to the Coroner's directions. The Claimant has also seen the BWV footage from 3 August 2021.

134. The legal test to be applied to the Claimant's application is whether disclosure is necessary to deal fairly and justly with a particular issue: see *R v Secretary of State for Foreign and Commonwealth Affairs ex parte World Development Movement Ltd* [1994] EWHC Admin 1, [1995] 1 WLR 386, at 396-397.

135. In my judgment, the BWV footage from 3 August 2021 is not necessary to deal fairly and justly with the issue in this claim, namely, the lawfulness of the IOPC's decision of 22 September 2023. The IOPC has never had possession of, or viewed, this BWV footage, and it played no part in its decision. I have no reason to doubt the evidence of Mughis Hassan, an IOPC Casework Manager, who has checked the database in the absence of Ms Watters. The IO, DS Greetham, has confirmed that the footage was not considered as part of her investigation nor provided to the IOPC. In a judicial review, it is not the Court's role to assess evidence which was not considered by the decision-maker, save in exceptional circumstances which do not arise here.

136. The BWV footage from 3 August 2021 has no bearing on the allegations in GMP complaint CO/00234/22 which was the subject matter of the IOPC's decision. Those allegations were that GMP should have investigated TM's domestic abuse allegations against RC; identified TM as vulnerable; provided TM with Clare's Law disclosure; and that TM's death could have been avoided if GMP had acted differently.

137. The complaint about the adequacy of the investigation that DI Humphreys undertook into the cause of TM's death on 3 August 2021, and whether RC was involved in her death, was not part of GMP complaint CO/00234/22. As the IOPC decision stated, at paragraph 7, it was outside the remit of that review. It was considered in GMP complaints CO/1735/21 and CO/00081/22, which were reviewed by DCI Jenkins. It has since been re-considered by DS Hughes in the PIP4 Review.

138. The Claimant's application for disclosure of the recording of the telephone conversation on 12 July 2021 relates to the complaint that GMP should have identified TM as vulnerable. The IOPC decision of 22 September 2023 considered the complaint at paragraphs 50 to 58, and the recording at paragraph 52. At paragraph 57, the IOPC concluded that, on the basis of the available evidence, the investigating officer "provided a reasonable rationale as to why Teresa was not identified, by GMP, as vulnerable" and she found the outcome of this complaint was reasonable and proportionate.

139. In her Further Grounds for judicial review, at paragraph 59, the Claimant submits that "it is paramount that the deciding Judge …listens to the 3 minute recorded telephone conversation between Teresa and PC Sharrocks on the 12th July 2021, before coming to a decision whether Teresa was or was not, vulnerable at that time.". Of course, it is not the role of the Court to make findings on the Claimant's complaints. However, in

the light of the weight that the Claimant placed on the recording, I considered it was necessary to listen to it, in order to deal fairly and justly with this aspect of the challenge to the IOPC's decision, and accordingly made an order for disclosure.

Conclusion

140. For the reasons set out above, permission to apply for judicial review is refused.