Investigation name:	**Chelsea Bridge**
IOPC reference:	**2022/170680**

Summary of IOPC conclusions

A summary of our conclusions and our rationale is set out below.

Metropolitan Police Service (MPS) - death or serious injury referral

We found no indication that any person serving with the police may have committed a criminal offence or behaved in a manner that would justify the bringing of disciplinary proceedings.

Performance

The investigation report sets out the actions that were taken by PC Ben Tugwell and PC Humphrey Tackie-yarboi in response to this incident, and the evidence available relating to the nature and extent of police contact before Mr Omishore's death, and whether the police may have caused or contributed to Mr Omishore's death. We considered:

(i) whether any person to whose conduct the investigation relates has a case to answer for misconduct or gross misconduct, or has no case to answer

(ii) whether or not disciplinary proceedings should be brought, and if so, what form they should take (particularly, the seriousness of any breach of the Standards of Professional Behaviour)

(iii) whether the performance of any person to whose conduct the investigation related is unsatisfactory and whether or not performance proceedings should be brought against any such person; and

(iv) whether or not any matter that was the subject of the investigation should be referred to be dealt with under the reflective practice review process.

We found no indication that any person serving with the police may have committed a criminal offence or behaved in a manner that would justify the bringing of disciplinary proceedings.

The Metropolitan Police Service agreed with our determinations and are satisfied that the report does not raise any performance issues.

Decision regarding complaints not subject to special procedures

We also investigated complaints made by the man's family about the MPS. We investigated whether the service provided by the MPS was acceptable.

Based on the available evidence, we were unable to reach a conclusion as to whether the service provided by the police was acceptable with regards to four complaints.

These included the MPS putting out a press release when the investigation had already been declared independent by the IOPC; that PC Tugwell and PC Tackie-yarboi may not have exercised their duties and responsibilities diligently and in accordance with their training; that they may have used unnecessary and/or disproportionate force that was not reasonable; and they may have behaved in a discriminatory manner towards Mr Omishore.

The matters complained about could either not be considered a service to Mr Omishore or his family or, it was not appropriate to view the officers' actions as such, and separately to whether there was any indication of misconduct or criminality.

We found that the service provided by the police was acceptable with regards to two complaints. These included:

- The MPS referring in the press release to Mr Omishore being "armed with a screwdriver" when the cigarette lighter had been seized by them and was in their possession.
- The delay in the lighter being handed over by the MPS to the IOPC and/or the MPS informing the IOPC that the exhibit was a lighter and not a screwdriver.

As set out in our final report, the first point was factually accurate. Several members of the public had reported witnessing a man holding a screwdriver. This was also communicated to the officers. The approach and content of the MPS press release was in accordance with the media relations protocol.

With regards to the lighter, there does not appear to have been a delay in this information being provided. Our staff did not view and obtain the lighter that day due to other actions that needed completing. Arrangements to collect the lighter were mutually agreed between us and the MPS.

We found that the service provided by the police was unacceptable with regards to one complaint:

- This related to the press release asserting that “a Taser was discharged but this did not enable the officers to safely detain him”.

We found that this went beyond the issuing of factual information as set out in the media relations protocol and risked pre-judging the outcome of the investigation.

> Learning

We carefully considered whether there were any learning opportunities arising from the investigation. We make learning recommendations to improve policing and public confidence in the police complaints system and to prevent a recurrence of similar incidents.

We found learning opportunities in respect of the police’s deployment communication, and mental health and Taser training. We also found that there was no lifesaving equipment located on the bridge.

This potential learning will be brought to the attention of the Coroner to inform the content of any preventing future death’s report and explored further with the MPS following the conclusion of the inquest.