

SECRETARIAT GENERAL

SECRETARIAT OF THE COMMITTEE OF MINISTERS
SECRETARIAT DU COMITE DES MINISTRES



Contact: Anna Austin
Tel: 03 88 41 22 29

Date: 18/06/2014

DH-DD(2014)809

Documents distributed at the request of a Representative shall be under the sole responsibility of the said Representative, without prejudice to the legal or political position of the Committee of Ministers.

Meeting: 1208 meeting (23-25 September 2014) (DH)

Item reference: Communication from a NGO (Rights Watch (UK)) (04/06/2014) in the cases of McCaughey and others and Collette and Michael Hemsworth against the United Kingdom (Applications No. 43098/09 and 58559/09)

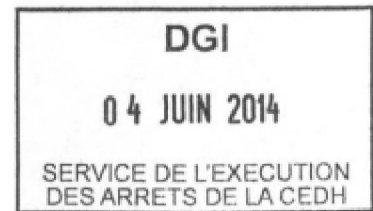
Information made available under Rule 9.2 of the Rules of the Committee of Ministers for the supervision of the execution of judgments and of the terms of friendly settlements.

Les documents distribués à la demande d'un/e Représentant/e le sont sous la seule responsabilité dudit/de ladite Représentant/e, sans préjuger de la position juridique ou politique du Comité des Ministres.

Réunion : 1208 réunion (23-25 septembre 2014) (DH)

Référence du point : Communication d'une ONG (Rights Watch (UK)) (04/06/2014) dans les affaires McCaughey et autres et Collette et Michael Hemsworth contre le Royaume-Uni (Requêtes n° 43098/09 et 58559/09)
(anglais uniquement)

Informations mises à disposition en vertu de la Règle 9.2 des Règles du Comité des Ministres pour la surveillance de l'exécution des arrêts et des termes des règlements amiables.



Submission to the Committee of Ministers from Rights Watch (UK) in relation to the supervision of the cases concerning the action of the security forces in Northern Ireland: Hemsworth v UK, judgement final on 16 October 2013 and McCaughey and Others v UK, judgement final on 16 October 2013

Our Mission: Promoting human rights and holding governments to account, drawing upon the lessons learned from the conflict in Northern Ireland.

Our Expertise and Achievements: Since 1990, Rights Watch (UK) (formerly British Irish Rights Watch) has held the UK Government and non-state actors to account for human rights abuses in conflict settings. We work with victims and communities to expose human rights abuses, to obtain redress and to hold those responsible for such abuses to account. Our interventions have reflected our range of expertise, from the right to a fair trial to the scope of the government's investigative obligation under Article 2 of the European Convention in Human Rights. We have a long record of working closely with Non-Governmental Organisations (NGOs) and government authorities to share that expertise. And we have received wide recognition, as the first winner of the Parliamentary Assembly of the Council of Europe's Human Rights Prize in 2009 alongside other honours.

1. This Rule 9 communication addresses the UK's Action Plan (15/04/2014) concerning Hemsworth and McCaughey and others cases.
2. Rights Watch (UK) has provided assistance to many individuals wishing to attain justice for themselves or their relatives due to events that formed part of the conflict in Northern Ireland. We have a great deal of experience of working with the Historical Enquiries Team (HET), the Office of the Police Ombudsman of Northern Ireland (OPONI), the coronial process, inquests and inquiries. We continue to work with individuals who have had to wait far too long for justice, and continue to support them in their use of the available legal mechanisms to access to the truth.
3. We note that violations of this kind have been found by the Court and addressed by the Committee before in 'the McKerr Group of Cases' which were subject to UK Government Action Plan (12/02/2014). We also would note the slow progress that has been made to rectify the issues addressed in these cases since 2001. We would therefore ask the Committee to consider this case and action plan in the light of the inaction of the Government since that time.
4. We believe that the UK Government has not acted quickly or effectively enough to remedy the failures in Article 2 compliance found in the McKerr Group of cases which has led to the

breaches in the of *Hemsworth* and *McCaughey* cases¹ and then refer thereafter to it as *Hemsworth* and *McCaughey*. In the Action Plan (15/04/12) the Government refers to the Haass Proposals and notes that Northern Ireland parties have yet to reach agreement on these proposals. We would note that the latter is not sufficient excuse for the UK Government not to have implemented full and comprehensive Article 2 compliant mechanisms. First the talks, which started in July 2013, lasted a relatively short period of time in the context of the years of delay that has been experienced in some of these cases². Further, the responsibility as a matter of international law, to ensure effective, independent investigations under Article 2 ECHR lies solely with the Government of the United Kingdom who retain the legislative powers to direct action to be taken by the devolved Ministers when required to fulfil international obligations.³

5. Within the 'General Measures' section the Government references the Criminal Justice Inspection Northern Ireland (CJNI) 'Review of the Cost and Impact of Dealing with The Past on Criminal Justice Organisations in Northern Ireland.' This report makes recommendations for the reform of the system for dealing with legacy cases within Northern Ireland to ensure that it is more cost efficient and delivers better quality results for victims and their families. Rights Watch (UK) agrees that budgetary and resourcing reforms are absolutely necessary for the systems of dealing with legacy cases. The inquest system provides a key example of where a lack of resources within agencies that are charged with important roles in relation to the delivery of inquests is contributing to endemic delay in the hearing of these inquests. Many of these agencies fall under the umbrella of the Department of Justice. Accordingly, it falls to that Department to provide the additional resources needed to ensure that the state is in a position to meet its Article 2 obligation to hold inquests promptly. There is obvious potential for conflict of interest in terms of effective facilitation of all aspects of the inquests going forward. Furthermore, where there are deemed to be national security implications, (as is the case of many legacy inquests), this entails the responsibility of central rather than devolved government, as national security is not a devolved matter. This responsibility seems to have been significantly abdicated to date which has resulted in inquests being insufficiently resourced.

6. The Government has not undertaken sufficient measures to rectify the problems identified in the McKerr Group of Cases. **We would therefore urge the Committee of Ministers to invoke its power under Rule 11 to issue infringement proceedings against the UK government for its failure to abide by the final judgements in the 'McKerr Group of Cases.'**

7. We now turn to the issues in the measures to address delay advanced by the UK Government.

Improving the Speed of Disclosure

8. We welcome the addition of personnel to the Legacy Support Unit (LSU) of the Police Service of Northern Ireland (PSNI). We hope that the PSNI will work quickly to ensure that

¹ *Hemsworth v UK*, no. 58559/09, ECHR 2013, *McCaughey and Others v UK*, no. 43098/09, ECHR 2013

² Section: Measures to Address Delay, UK Action Plan (15/04/2014)

³ S 26 -27 of the Northern Ireland Act 1998.

outstanding vacancies are filled with high quality candidates who will ably assist this unit in its work.

Cross Agency Working Group

9. We also welcome the creation of a cross-agency working group. We believe that such a group could ensure that there is less inefficiency in the system and provide better access to justice in the long term, if prompt and coordinated actions are taken to remedy the problems in the system. We believe that it is important that major stakeholders are engaged in this purpose, and hope that strong leadership is displayed by the Northern Ireland Courts and Tribunals Service (NICTS). We notice that this group does not include the Ministry of Defence (MOD) or MI5 who are both involved in legacy cases. We would argue that these organisations should be involved in discussions about how disclosure could be made more efficient and effective. Without their inclusion any plan of action is likely to be incomplete in its effect and reach. We would also question why greater input from the families and legal representatives who work within the system has not been sought, so as to ensure that the group can effectively target the problems in the system.
10. The agreement of inter-agency protocols on disclosure is likely, on the basis of past experience, to be time-consuming and unwieldy absent the setting down of clear legislative parameters or other guidance as to what such protocols should contain in terms of balancing rule of law considerations with security imperatives, which may, potentially be overstated. This issue is clearly demonstrated in the current legal challenge launched by the OPONI against the PSNI, which is discussed below, where the PSNI is not complying with the MOU it has with PSNI concerning the disclosure of sensitive information.
11. **We would therefore urge the Committee of Ministers to closely scrutinise the work and remit of the Cross Agency Working Group to ensure that it has sufficient scope and membership to adequately deal with issues of disclosure, and to satisfy its terms of reference fully.**

Addressing Delay in Inquest Proceedings

12. We note that concerns into delays in inquests have been raised repeatedly of recent⁴. Notable is the letter from Senior Coroner John Leckey's Office to the Justice Minister of Northern Ireland, stating that an inquest is being 'funded on a drip by drip bases' with 'no demonstrable commitment' to ensure they are properly resourced⁵. Inquests into 75 legacy deaths remain outstanding.⁶
13. Despite the fact that the inquest system is both outdated (in terms of legislation which never had its current expansive role in contemplation) and has lacked sufficient overhaul (except piecemeal by case law), inquests remain the State's mechanism for fulfilling its procedural

⁴ <http://www.theguardian.com/uk-news/2014/apr/13/delay-northern-ireland-troubles-inquests-outstanding>

⁵ <http://www.thedetail.tv/issues/318/coroner-attacks-nio-doj/coroner-launches-unprecedented-attack-over-delays-in-shoot-to-kill-inquests> ,

⁶ <http://www.belfasttelegraph.co.uk/news/local-national/northern-ireland/75-killings-and-still-no-inquests-30211340.html>

obligations under Article 2 in relation to conflict-related (and other) deaths. This is in a context where coronial inquiry has been attended by endemic delay linked to lack of expeditious disclosure, inadequate legislation and resourcing limitations.

14. The judgment in *Middleton*⁷ sets out clearly:

...In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that his inquest is the means by which the state will discharge its procedural investigative obligation under article 2. [1]

15. Coronial investigative duty in such cases was summarised by Lord Bingham in the House of Lords case in *Amin*⁸ as:

To ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost a relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.[2]

16. The *Hemsworth and McCaughey* cases indicate that the inquest system has not been rendered effective to achieve Article 2 compliance in these kinds of cases at this point in time.

17. The Government has continually underfunded and resourced this vital work and we welcome the Government's commitment to providing more resources and reform in the action plan. However the failure to act since the 'McKerr Group of Cases' and the slow pace of progress fills us with little confidence that this will be the case.

18. It would appear that the government has neither moved in a timely way to address the stringent criticisms set out in *Hemsworth and McCaughey* judgment. Nor does it appear to have undertaken any kind of effective consultation in formulating its current plans or considering the extent to which the plan a) address all issues requiring to be addressed, b) are workable in practice.

19. The problems are acute across a range of legacy inquests, and these cause a knock-on effect for the broader coronial workload issues. There are clear areas which the government's plan for inquests does not appear to address and this lack of foresight and proper drilling down into the mechanisms proposed is highly problematic in terms of the delivery of Article 2 compliant inquests.

20. The previous package of measures has failed in significant degrees. Given the length of time it has taken to get this far, intense scrutiny is required of current proposal so that a smoke and mirrors suggestion that all will now be well is not permitted to set up another set of

⁷ R (Middleton) v West Somerset Coroner [2004] UKHL 10

⁸ R v. Secretary of State for the Home Department (Respondent) ex parte Amin (FC)

processes which, through lack of sufficient thinking through are themselves likely to be insufficient to bring satisfactory resolution in this context.

21. Coroners, in particular, the Senior Coroner, have often expressed concern, frustration and, indeed embarrassment in respect of how slow progress has been in respect of a whole range of individual cases. Indeed a recent High Court decision has seen compensation ordered in respect of 6 legacy cases (one of them, *Jordan*⁹ which has already been before the Strasbourg Court several years ago now) for the distress families have suffered in the context of inquests still not having been held into the deaths of their loved ones.
22. The McKerr case which gave rise to the original package of measures is indicative of endemic problems in the current system. While the inquests have still not been held, it is difficult to see how the Hemsworth Action Plan will assist to any real degree. There is clearly a need for further resources to be applied in ease of both the disclosure process and coronial investigative requirements. However, the processes and systems in place to advance such matters are both overly bureaucratic and highly inefficient in terms of the avoidance of delay. It is difficult to see that the Action Plan seriously addresses either of these realities. Part of the problem is that the Action Plan lacks any real detail in the areas where one would require it to make any real assessment of the viability of the approach proposed,
23. In the Stalker Sampson series of inquests, which include the 'McKerr group of cases', a range of stakeholders are competing for limited resources from the same pool, and appear to have been insufficiently resourced in terms of the necessary structures, systems and funding to ensure Article 2 compliance. It is unclear how a Legacy Inquest Unit (LIU) and a cross-agency working group will address these issues per se, without much more detail as to remit, composition of bodies, etc.
24. We note that the Legal Aid and Coroner's Courts (Northern Ireland) Bill is currently under consideration in the Legislative Assembly for Northern Ireland. However this does not contain the significant reforms of the Coroner's Courts that would be needed to address the issues surrounding inquests in Northern Ireland.
25. The lack of appropriate powers within the Coroner's Act (NI) 1959 and the attendant 1963 rules do not appropriately lend themselves to the efficient delivery of Article 2 compliant inquests. Coroners lack sufficient powers in practical terms to ensure directions are complied with. Their only real sanction is JR and this is likely to be evoked only in a last resort. It is a highly unsatisfactory way for one public authority to have to do business with another.
26. The only current proposal in terms of new legislative provision is to make the Lord Chief Justice President of the Coroners' Court and to place the post of Presiding Judge on a statutory footing. A range of other compelling lacunae within the coroner's legislation and rules, will not be addressed by the Coroner's Courts having a President or by a higher judicial tier hearing legacy cases. For example, there is also a provision in England and Wales

⁹ *Hugh Jordan v Senior Coroner* [2009] NICA 64

(Coroners and Justice Act 2009) not currently in place in NI that make it an offence to fail to comply with coronial direction for witness to appear and bring relevant documents. The clear limitations of legislative provision in this area have already been the subject of prior judicial comment in case law.

27. The 2009 comments of the Northern Ireland Court of Appeal in *Hugh Jordan v. the Senior Coroner*¹⁰ remain instructive in this regard:

The current state of coronial law is extremely unsatisfactory. It is developing by means of piecemeal and incremental case law. It is marked by an absence of clearly drafted and easily enforceable procedural rules. Its complexity, confusion and inadequacies make the function of a coroner extremely difficult and...called on to apply case law which does not always speak with one voice or consistently.

It is not apparent that entirely satisfactory arrangements exist to enable the PSNI to dispassionately perform its functions of assisting the coroner when it has its own interests to further and protect. If nothing else, it is clear from this matter that Northern Ireland coronial law and practice requires a focused and clear review to ensure the avoidance of the procedural difficulties that have arisen in this inquest.'[\[1\]](#)

28. Despite this, an administrative solution is proposed in preference to a legislative one. There is a commitment to review whether there is a need for changes in the law - but this is already clear and should have been actioned long before now. In terms of the substance of the administrative proposal to date there is insufficient detail about how a Legacy Inquest Unit (LIU) would function to enable substantive meaningful comment to be made as to whether such a unit would be sufficiently able to inject article 2 compliance into the current system. It is clear that the devil will lie in the detail in terms of the potential (or otherwise) of any such unit to rectify service delivery problems in relation to inquests, and it is considered at best unfortunate, at worst disingenuous and calculated to mislead, that sufficiency of detail is lacking at this point in the process where this is the government's proposed way forward out of an impasse of its own making.
29. It would be very helpful to understand more precisely how it is envisaged that the LIU would operate to deliver evidence consideration by legal officers and any further coronial investigation required, management of inquest preparation and the facilitation of holding inquests. Again, detail would be required to properly appraise this aspect of the proposal in terms of its own fitness for purpose. The extent of interface with coroner's service and individual coroners would need to be made very clear, with lines of responsibility, monitoring, reporting and accountability clearly defined and delineated.
30. Disclosure is a fundamental issue, to which it appears insufficient attention has been given in proposals for change to date. In many ways, insufficiencies in the systems for delivery of fulsome and timely (well-ordered and indexed) disclosure are the main stumbling block to

¹⁰ *Hugh Jordan v Senior Coroner* [2009] NICA 64

progress. No amount of restructuring or additional judges is going to assist in reducing delay unless something fundamental can be done to speed up the identification and delivery of potentially relevant disclosure.

31. The Stalker Sampson series of inquests (which include McKerr) have flagged up the sensitivities in terms of perceptions of independence that are inherent in the PSNI taking the lead on disclosure particularly where there is deployment of staff with former service in RUC Special Branch/Intelligence systems who have stated knowledge of 92 potential witnesses in the Stalker Sampson cases. This issue is not addressed in the Government Action plan.
32. The Stalker Sampson cases indicate that disclosure is not just an issue for the PSNI. In these cases, the coronial system requires disclosure from many agencies/individuals over and above the PSNI, including, but not limited to MOD and MI5. The extent of the duty of other government agencies to assist in a timely and fulsome manner in the identification and provision of potentially relevant material to the Coroner conducting an investigation, requiring to be Article 2 compliant, must be clearly spelt out for the avoidance of doubt and practical enforcement mechanisms introduced to ensure expeditious delivery of material in good order.
33. Proper archival and information management and retrieval systems are required as a matter of urgency. The government action plan does not begin to grapple with the reality of what is involved here.
34. The Action Plan proposes a review of legislation, but in a context where a decision appears to have been taken that changes in legislation will not be particularly useful in terms of the reduction of delay, and that changes to legislation are not warranted as a matter of urgency. This assumption is erroneous.
35. It has long been clear that a fundamental review of the fitness for purpose of the coroner's legislation and rules is required in terms of the structural capacity of coroners (or, indeed, any other judge sitting in a coronial capacity) to deliver article 2 compliant inquests. Difficulties in this regard were highlighted in very strong terms by the Strasbourg Court in *Hemsworth and McCaughey* . It is unclear why further amendment to legislation is not more urgently contemplated, with a view to remedying insufficiencies in coronial powers, processes and enforcement mechanisms that have been apparent now for a considerable number of years.
36. A number of issues occur in relation to the lack of detail attending the current proposal for the allocation of legacy inquests to judges at County Court and/or High Court level.
 - It does not address the deficiencies in coronial legislation/powers which will continue to impact no matter who is sitting as a coroner.
 - Even High Court judges will find themselves fettered by the coronial legislation unless they are sitting on a different statutory basis

- Many of the Judicial Reviews that have arisen from inquests relate very particularly to failings/gaps in the legislation/rules which the current proposals do not address.
- The NI Court of Appeal in *Jordan* recently indicated the benefits of a case stated procedure to assist coroners wishing to clarify aspects of law and legal principle in a manner which would not involve them requiring to become an adversarial party in legal proceedings. This is clearly an area which requires to be further explored.
- The plan does not address the practical implications of judges sitting as coroners, in terms of the necessity of their appointment as Coroners under the 1959 legislation and subject to NIJAC recruitment processes

37. We would therefore recommend that the Committee of Ministers carefully scrutinises the current action plan and the actions that are being taken, to ensure that any reforms taken will adequately and effectively improve effective legacy inquests.

Improving Office of the Police Ombudsman Northern Ireland (OPONI) Investigations

38. Rights Watch (UK) has made submissions to the Department of Justice consultations on OPONI¹¹ and we continue to support the conclusions we made in those submissions. We wish to highlight to the Committee the following aspects of our submissions that we believe are particularly pertinent to assessing the Government's action plan.
39. We wish to remind the Committee that the Government has failed to give OPONI sufficient powers to carry out its role of effectively investigating historic cases by not accepting recommendations 17 and 20 of the Five Year Review (2007).¹²
40. Recommendation 17 stated that: the Police Ombudsman be given powers to compel retired or former police officers to submit a witness interview and to provide all relevant documentation to him, which is within their possession, custody, power or control when he is conducting investigations involving grave or exceptional matters.
41. Recommendation 20 stated that the Police Ombudsman should be able to investigate deaths occurring either directly as a result of police action or indirectly due to police operations despite the fact that the death might otherwise have been previously investigated by police.
42. In addition to the abovementioned recommendations, we also note the importance of the four further proposals presented in October 2013 by the Department of Justice in relation to the Police Ombudsman:
- Recommendations and findings by the Police Ombudsman should be binding on the PSNI Chief Constable;

¹¹ <http://www.rwuk.org/new/wp-content/uploads/2013/08/OPONI-Consultation-13-08-13.pdf>
http://www.rwuk.org/new/wp-content/uploads/2013/11/Consultation_11_11_13.pdf

¹² As part of the Police Ombudsman's Five Year Review of Powers, there were a series of suggested reforms which were aimed at remedying the gaps in OPONI's remit.

- The PSNI should not interview or debrief serving or retired officers who are known to be witnesses or suspects in an existing or impending investigation by the Office of the Police Ombudsman;
- The Police Ombudsman must be empowered to arrest and interview agents and informers [sic] of the PSNI (or any other agency) if it may assist an investigation by the Police Ombudsman; and
- All protocols or memoranda of understand (MoU) governing the release of information from the PSNI and other agencies to the Office of the Police Ombudsman to assist an investigation should be available for scrutiny by the Policing Board/Justice Committee.¹³

43. We believe that these six recommendations would strengthen the accountability framework and go some way to ensuring that the OPONI has sufficient powers so that its investigations comply with the procedural obligations under Article 2 ECHR.

44. Rights Watch (UK) calls on the Committee to carefully review the Government's failure to fully implement the recommendations of Five Year Review (2007) and consider what steps are being taken by the Government to ensure that the devolved administration makes necessary reforms to ensure that the OPONI has sufficient powers so that its investigations comply with the procedural obligations under Article 2 ECHR.

45. We also wish to highlight to the Committee of Ministers the new legal challenge brought by the OPONI against PSNI due to the failure of PSNI to disclose information¹⁴. Rights Watch (UK) is deeply concerned that the PSNI feel it acceptable to withhold information from an independent oversight body such as the OPONI. The OPONI has a security cleared intelligence unit and a Memorandum of Understanding with the PSNI about how sensitive material is requested, obtained and dealt with. The PSNI are legally required to provide the Ombudsman with information¹⁵ and we see this as an unacceptable obstruction to holding the police accountable for alleged wrongdoing. We think it unacceptable that the PSNI decides what information can be accessed by an independent oversight mechanism. This fundamentally undermines the independence and efficacy of the OPONI review procedure and raises serious questions as to whether it complies with the investigatory obligation under Article 2 of the ECHR. We are closely monitoring this case and if appropriate, will seek to intervene in the judicial review.

46. We would urge the Committee to consider whether such a failure in disclosure by PSNI constitutes a failure to abide by the final judgements in these cases and the 'McKerr Group of Cases' and fundamentally frustrates and undermines the power of OPONI to conduct investigations that comply with the procedural obligations under Article 2 ECHR. We would urge the Committee of Ministers to ask the Government to provide it with an explanation of why the PSNI are withholding information and how this is justified given

¹³ Department of Justice Policing Policy Strategy Division Letter to consultees, 19 October 2013

¹⁴ http://www.policeombudsman.org/modules/press/press.cfm/Press_ID/386/action/detail/year/2014

¹⁵ Section 66 of The Police (Northern Ireland) Act 2000.

the abovementioned MOU, legislation and processes in place for holding sensitive information.

47. We have also made two submissions to the working group of the Northern Ireland Policing Board (NIPB) about the implementation of Her Majesty's Inspectorate of Constabulary's (HMIC) Report into the Historical Enquiries Team.¹⁶ HMIC's report found that the HET:
- Lacked a clear purpose, organisational structure, policies and processes
 - Did not have sufficient accountability structures in place
 - Treated military and non-military cases differently unjustifiably as a matter of policy
 - Failed to adequately investigate cases where the state had been involved in the killings in a manner consistent with Article 2 ECHR Failed to ensure it received all the information it could from Government and Police
 - Failed to ensure its staff was independent
48. As such the work of the HET in relation to State cases was suspended in October 2013. The Northern Ireland Policing Board commissioned a Working Group to oversee the recommendations of the HMIC report. The Working Group has carried out extensive consultation with a range of stakeholders, victims' families and NGOs and has met on 19 occasions since the publication of the HMIC Report on 4 July 2013.¹⁷ The Working Group has recommended the establishment of an oversight panel to oversee the work of the HET which is thoroughly independent and has raised a number of concerns relating to the implementation of HMIC's recommendations. The Working Group has asked HMIC to prioritise undertaking a follow up review of HET to evaluate the implementation of the twenty recommendations made in the initial report. We remain concerned that the recommendations made by the HMIC have not been and are not being adequately implemented which raises very serious questions about the Article 2 ECHR compliance of the HET process. Finally we note that there remain serious questions of whether the HET, even if reformed, can deliver article 2 compliant investigations. We continue to call for the establishment of thoroughly independent mechanism as envisaged in the Haass proposals as the best means of ensuring Article 2 complaint investigations.
- 49. We urge the Committee of Ministers to carefully and continually review the implementation of the HMIC recommendations and require the Government to provide information as to how the reforms are being implemented to ensure Article 2 complaint investigations. We also urge the Committee of Ministers to ensure that an appropriate system is established to oversee the implementation of the recommendations. Finally, we would request that the Committee of Ministers reopened its scrutiny of the general measures relating to HET in the 'McKerr group of cases' and ask them to carefully scrutinise the action plan provided in this case**

¹⁶ http://www.rwuk.org/new/wp-content/uploads/2013/11/Briefing_Note_to_NIPB_1.pdf
http://www.rwuk.org/new/wp-content/uploads/2013/11/Briefing_Note_to_NIPB_2.pdf

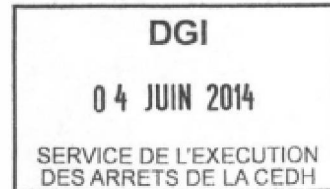
¹⁷ See attached letter from Chair of HET working group of Policing Board of Northern Ireland.



Brice Dickson
Chair – HET Working Group

Date: 13 May 2014

Rights Watch UK
32 -36 Loman Street
London
SE1 0EH



Dear Sir/Madam

NORTHERN IRELAND POLICING BOARD HET WORKING GROUP

As Chair of the Northern Ireland Policing Board's HET Working Group, I am writing to update you on the work undertaken in overseeing PSNI's implementation of the recommendations made by Her Majesty's Inspectorate of Constabulary in its inspection of the Historical Enquiries Team.

The Working Group has carried out extensive consultation with a range of stakeholders, victims' families and NGOs. The Group has met on nineteen occasions since the publication of the HMIC report on 4 July 2013. Members also met with the Chief Constable on seven occasions and, since 16 October 2013, held monthly meetings with David Ford, the Minister of Justice, to enable the Working Group to keep the Minister up to date on developments and discussions taking place. Three meetings also took place with Steve Otter from HMIC, as well meetings with Professor Lundy. Meetings have also been held between the Group and Baroness O'Loan and Richard Harvey from the Operation Stafford Independent Panel, and Paul Leighton and Phil Scraton from the Hillsborough Independent Panel in order to inform the Group's thinking on the establishment of an oversight mechanism to oversee the work of the HET in the future.

Members have formulated their views on a number of issues and I am taking this opportunity to provide you with an update.

Review Summary Reports

In relation to the release of Review Summary Reports (RSRs), at the beginning of its consideration of the HMIC Inspection of HET, and in consultation with some families affected by the Review, the Board agreed that the HET should continue the process of conducting reviews in non-military cases but, as a precautionary measure, should not finalise or release reports in those cases. Subsequently some stakeholders expressed the view to the Working Group that it was their preference that all completed reports should be issued to families in non-military cases and they sought the Working Group's view as to how this may be achieved.

Handwritten signature

Northern Ireland Policing Board

Waterside Tower, 31 Clarendon Road, Clarendon Dock, Belfast BT1 3BG

Tel: 028 9040 8500 **Fax:** 028 9040 8525 **Textphone:** 028 9052 7668

Email: information@nipolicingboard.org.uk **Web:** www.nipolicingboard.org.uk

f [policingboard](https://www.facebook.com/policingboard) **t** [@nipolicingboard](https://twitter.com/nipolicingboard)



The view had been expressed to the Working Group by the Chief Constable and Assistant Chief Constable Crime Operations that the 34 Review Summary Reports which have been completed since July 2013 could not be released in their current form. Based on its consultation with a range of stakeholders, the Working Group disagreed that there was any justification for altering either the format or content of the RSRs. The Chief Constable & ACC Crime Operations recently confirmed at the 1 May 2014 Board meeting that completed RSRs will be issued as soon as practicable and that original reports will also be made available on request.

Oversight Panel

The Board has also initiated discussions with the Minister of Justice to express their view that an oversight panel be put in place to oversee the work of HET. Members have agreed that the independence of the panel is absolutely critical and that trust and integrity amongst panel members must be a core value. It was also agreed that the panel should have due regard, not only for the specific interests of the families of victims but also for the more general interest of the public at large in ensuring the accountability of the PSNI.

PSNI Progress Reports

Beyond the issues of RSRs and the establishment of an oversight panel there remain a number of concerns relating to the implementation of HMIC's recommendations. The Board received two progress reports from the PSNI on 12 December 2013 and 27 March 2014. Based on these progress reports and discussions with the Chief Constable the Board has submitted a report to HMI Steve Otter and asked him to prioritise undertaking a follow-up review of HET to evaluate the implementation of the twenty recommendations made in the initial report. The Board is mindful that the successful implementation of the recommendations has been framed by HMIC within the context of Article 2 compliance and Members agree that there must also be community confidence in HET to carry out reviews into historical deaths.

The Board is aware of community sensitivities regarding the future operation of the HET and believe that a follow-up review by HMIC is the best means of determining if the changes implemented by the Chief Constable ensure the Article 2 independence of the HET. The Board is taking further advice on this matter. The Board will write to you again when a date for a follow-up inspection by HMIC has been agreed by PSNI and the Board.

Yours sincerely

Brice

Brice Dickson
Chair - HET Working Group