

INQUEST Submission to the Independent Review

Wider points arising out of Sean Rigg's case

Recognising the political and historical context of deaths in police custody and their investigation

There must be a greater recognition by the IPCC of the broader political and social policy context in which deaths occur and the history of the police complaints system. The IPCC was set up as a direct result of the disquiet over a number of high profile deaths and the lack of an independent police complaints system. Historically the impact of deaths in or following police contact has been profound - in particular on police and community relations - resulting in a lack of confidence in the investigation process and untold anger particularly among the BAME communities about the number of deaths following the use of force or medical neglect and the failure to hold the police to account for wrongdoing.

Sean Rigg's death took place in Brixton, a community that had a history of previous high profile black deaths in custody [Brian Douglas, Wayne Douglas, Ricky Bishop, and Derek Bennett] as well as concerns about oppressive policing generally e.g. the disproportionate use of stop and search. A number of these deaths (as in the recent case death of Mark Duggan) were catalysts to considerable public anger and community based disturbances to what was perceived as pervasive state violence with impunity. In the light of this history it could reasonably be expected that those involved at the IPCC would have this knowledge base at the forefront of their minds and recognise their role in satisfying the serious public interest in this death and the family's need to see a robust and demonstrably independent investigation from the outset. The failure to recognise the serious questions this death raised – a young black man with mental health problems dying in Brixton police station after being arrested by police officers - sowed the seed for the lack of family and public confidence in the IPCC from the outset of its involvement.

The IPCC's approach on this and other cases suggests a lack of full understanding or priority being given to its wider guardianship role. Of equal importance to its inward facing investigation role is its outward facing public interest role in upholding policing standards and ensuring that the police service is accountable to the community it serves.

Setting cases in context

- From the outset the IPCC needs to expressly situate an individual investigation within this broader context that includes community concerns and perceptions, broader policing concerns, previous cases raising similar issues or involving the same police force/police station. It should set an investigation within the context of IPCC's own policy

- landscape (in terms of statistics, thematic reviews, and previous investigations), identifying patterns and common themes and concerns.
- In any contentious case, the IPCC need to quickly recognise and respond to wider public interest and concerns; identifying considered methods and strategies for engaging and informing the community throughout the course of an investigation. This is essential to the IPCC rebuilding public trust and confidence in its capacity to do the job properly.
 - The IPCC should not be afraid to identify the primary, contentious features in a case e.g. mental health, restraint and race. This is not to prejudge the investigation or with the purpose of ruling those issues in or out but to make clear the IPCC is aware of and has identified the primary concerns and issues that need to be examined. To put on public record that the IPCC recognises the important questions and issues to explore and is there to conduct a robust investigation will go some way to satisfying the public interest and concern about these deaths.

Discrimination Issues

An effective police complaints system must include rigorous consideration of discriminatory treatment and practices. INQUEST has documented how a disproportionate number of people from Black and Minority Ethnic communities and those with mental health problems have died following the use of force (a fact also acknowledged in the IPCC's own published statistics) raising concerns about racism and discrimination by state agents.

In INQUEST's experience the issue of discrimination and whether the death can be linked to discriminatory attitudes and practices is never adequately considered by the IPCC in its investigations.

Many of the cases INQUEST has worked on have presented disturbing images of violence and racism – ascribing to black people stereotypical characteristics of extraordinary strength, dangerousness and criminality thus attempting to blame the victim for their own death either by their pathological condition or their personal choice.

Another group over represented are people with mental health problems where 'negative imagery' once again informs their treatment - the stereotype of the mentally ill as 'mad', 'bad' and 'dangerous'.

Cases have revealed a use of violence on some occasions that is greatly disproportionate to the risks posed, raising questions about the attitudes and assumptions of some state officials and pre-conceived ideas about the propensity to violence of particular groups of people.

In the context of black deaths in custody the issue of race/racism is not referred to by the IPCC or included in the terms of reference. Evidence of

racial stereotyping by the Metropolitan Police led to the most damaging censure of the police when a public inquiry attributed the bungled police investigation into the racist murder of Stephen Lawrence to institutionalised racism. INQUEST is concerned that racial stereotyping has been a contributory factor in some of the deaths in custody resulting from restraint/use of force and medical neglect. The question of racism is therefore the 'elephant in the room' neither part of the investigation process nor inquest. Similarly INQUEST is not aware of investigations that look specifically at whether discriminatory treatment of people with mental health problems may have contributed to the death. With the increasing concerns about mental health and policing, this is an urgent issue that needs addressing. INQUEST is also concerned with the double discrimination experienced by black people with mental health problems.

Language

It is important that the IPCC recognises the danger of using 'value laden' language and separating the author of the report from those giving their accounts of what happened. This is particularly important in cases that have involved the use of force or in the context of mental health. It is common in Terms of Reference and investigation reports to see references to 'violent' and 'aggressive' - behaviour as described by police officers – in many cases found subsequently to be language used to justify their actions that other evidence suggests is 'disorientation' and 'agitation'. As well as being offensive to families, such value laden language risks distorting the picture of events and the prejudging of evidence.

Multi agency work

The IPCC should identify where the policing role sits within the wider picture of other relevant agencies, e.g., a case involving policing and mental health should define the wider landscape including interface with other relevant bodies e.g. social services, mental health services, NHS Trusts etc, so that the issue of joint protocols, policies and good practise etc are addressed. This is also crucial for the IPCC's oversight role in drawing public and policy attention to issues arising from the investigation of deaths and complaints.

IPCC initial response

Sensitive and thorough handling of the investigation in the 'golden hours' following the death is critical to evidence gathering and setting the direction and quality of the investigation to follow.

Current IPCC guidance on the Mode of Investigation decisions following death in custody is not clear, contributing to systemic failures in the timing and nature of MOI decision making immediately following a death.

Evidence came out during Sean's inquest that the IPCC were present at a meeting in Brixton station in the early hours following his death. All but one of the key officers were present and (on the evidence of one of the arresting officers) shared accounts in the presence of senior management, the Police Federation and IPCC. When asked by the coroner to explain their presence the IPCC said that a MOI decision had not yet been taken and therefore their attendance was limited to "observers". IPCC notes from that meeting appeared in the unused materials and were poorly written and incomplete.

The initial IPCC response and timing is crucial. All initial action, evidence gathering, protection of records etc. flows from that decision. Why was there such a delay in making that decision particularly given the above context concerning Brixton police station? The consequences of that delay were seriously damaging to the family and public confidence which once undermined is difficult to restore. In giving evidence to the inquest on this point, Peter Moore of the IPCC worryingly did not indicate any concerns or suggest that the position would be different now. This points to the need for clear guidance and protocols as to the critical work to be done in the 'early hours' after a death and any action taken noted in a log. It also raises ongoing concerns about the failure of the IPCC and Metropolitan Police treating all scenes where force/restraint is used as a potential crime scene(s), a situation too often seen in cases involving the use of force.

Where there is a history of poor police community relations or a death following the use of force the presumption should be for an immediate independent investigation.

Conferring/collusion

The case of *Saunders* prohibits conferring between officers, albeit in that case following police shootings.¹ This is essential to protecting the integrity and honesty of officer accounts following all deaths in custody and to prevent corruption of the evidence gathering stage. There is currently a lack of guidance or mechanisms on the ground to enforce this and examples of conferring, as with Sean's case, are common. This issue is currently the subject of a Judicial Review. The IPCC account at Sean's inquest of attendance "as observers" suggests a lack of institutional understanding of the importance of the requirement. The IPCC should be enforcing this requirement through its own practices but are currently failing to do so. Instructions not to confer or collude should be issued by the IPCC from the moment they become notified of a death, with a description of the consequences. Every officer interviewed should be asked whether they have discussed the case with anyone else. This acts as a protection both for the

¹ *R (on the application of Saunders) v IPCC* [2008] EWHC 2372 (Admin), 10 October 2008
<http://www.bailii.org/ew/cases/EWHC/Admin/2008/2372.html>

officer and the integrity of the investigation.

Systems/protocols in place to direct IPCC at each stage

Are there written protocols that set the framework for the way the IPCC approaches each case? Experience in Sean's and other cases are of an adhoc, often chaotic system which appears to be directed by an individual rather than according to an agreed organisational method or structure. Is the IPCC working according to protocols, checklists etc? Why in Sean's case were there such basic failures, for example, in the collation and protection of key evidence at the outset. Does a protocol exist directing urgent initial steps, evidence gathering (audio, CCTV, 999 calls from public, radio airwaves, uniforms, equipment, records of vehicles involved etc.)? Working checklists and protocols could be reviewed and updated to ensure continued organisational and individual learning after every case. What documents underpin the IPCC's internal training for those conducting investigations?

To ensure a uniform approach, within which professional judgement is exercised on a case by case basis, the IPCC should put in place clear, coherent and consistent national protocols for the structure of the relationship between the investigating officials and all others in direct contact with bereaved people and ensure that investigations follow an agreed basic protocol.

Interviewing officers

The failure to interview police officers is one of the most contentious issues concerning deaths in custody, particularly those cases that follow the police use of force. The perceived reluctance to interview under caution arises in the majority of cases and for most families goes to the heart of the issue of independence and why it is that police officers are treated differently than other citizens. There is a current lack of understanding or reluctance by the IPCC to utilise its existing powers to interview under caution. What accounts for the failure to use powers to interview? Lack of clear guidance? Lack of training? Lack of confidence? It also raises questions about whether the culture within the IPCC is such that it cannot countenance the idea of criminality or whether it is illustrative of collusion between investigators and officers to conceal potential wrongdoing.

Full and detailed first accounts should be obtained immediately from all relevant officers. In Sean's case all hostel staff were interviewed within 10 days, and yet it was months before any police officers were interviewed. Meanwhile, none provided fully completed notebooks (as to which see further below) or other full contemporaneous accounts – the partial notebook entry of one arresting officer and partial statements of the other three arresting officers were woefully insufficient, while none of the other officers made any form of contemporaneous record. New powers are being introduced to enable the IPCC to interview all officers as witnesses. It is important there is full

understanding and utilisation of powers that currently exist which enable officers to be interviewed as suspects (with due legal process and the safeguards that provides) where misconduct or a criminal act may have occurred.

Interviewers need a detailed understanding of the evidence. Further interviews should take place once evidence has been analysed to address gaps/conflicts. Some standard questions should exist and be asked of all police officers. e.g., all officers should be asked about conferring.

Completing Evidence and Action Books (EAB's)

Although a requirement for every officer to record anything that may be of evidential value, it is common, as with Sean's case, for officers not to complete their EABs where a death has occurred. Greater action is needed by the IPCC on this point for example the recommendation of disciplinary action where this does not occur and where it is identified as a thematic issue it should be brought to the attention of senior officers, ACPO and the Police Federation.

Key points to be raised with the police

The IPCC should have a checklist of issues that need to be raised with the police following a contentious death e.g., instruction not to confer, to complete EABs, to attend interviews, to consider suspension of officers, disclosure, crime scene, witness boards. Those key issues should be recorded in the report to show they have been considered and raised (including dates, parties involved etc.) together with the outcome/response recorded. E.g. if a Chief Constable has refused to suspend officers following an IPCC request, that should be recorded in the final report.

Investigation process- Improving confidence, robustness and quality

The IPCC needs to be more confident and more organised at all stages in the process. Developed systems, structures and methodology would make a significant difference. Even now the IPCC's initial contact with a family appears ad hoc and chaotic suggesting a basic lack of systems and approach: some families are consulted on initial press releases, some are not; on some cases the family will be invited to meet with the commissioner, on others they are not. It is common to attend an initial meeting with a family following a death without an agreed agenda. The room for anger and frustration in such poorly prepared meetings is considerable. IPCC staff leading these meetings need to be appropriately skilled and/or trained in chairing and running highly sensitive meetings.

The need to identify all key contentious features of a case to ensure these are properly addressed in the investigation and report

- Identification of the key features of a case is essential to informing the investigation approach. In Sean's case these features included mental illness, restraint and race. All issues were inadequately addressed. For example, concerning the restraint, a proper analysis of the evidence by the IPCC should have shown (as it did at the inquest hearing) that Sean was initially restrained by officers for 8 minutes rather than for a matter of seconds as claimed. In stark contrast to the IPCC's findings, the jury found that the restraint used amounted to excessive force and more than minimally contributed to his death. In light of previous restraint related deaths one would have expected a more challenging and robust review of the use of restraint.

Pre-conceived opinion of what has occurred

- In Sean's and other cases, the IPCC appear to quickly form a fixed picture of events. Evidence can become selected and reviewed according to that fixed view; a view which is often sympathetic to, or informed by, the police account and an uncritical acceptance of their evidence. This helps contribute to a family belief that the IPCC lacks rigour and independence and is not impartial in its approach. There is also the danger that important evidence, lines of inquiry and witnesses can become overlooked and minimised.

Poor quality of evidence gathering and analysis

- The failure to robustly collate, analyse, review and challenge evidence is suggestive of either a lack of will or a lack of skills and training. There were many instances of poor quality evidence gathering in Sean's case e.g. a failure to view critical CCTV evidence which showed that Custody Sgt White did not go to the van to make a check on Sean as claimed in his evidence. It is also illustrative of an uncritical acceptance of police accounts.

Systems for dealing with large volumes of material and evidence

- Current experience, including in Sean's case, suggests some difficulty in dealing with contentious cases involving large volumes of documents. There needs to be a review of systems currently in place. What is the impact if the investigator changes?

Choice and selection of experts

This is often a highly contentious area. There needs to be greater agreement and discussion about how and when to use them. The IPCC should also be utilising experts to help address any gaps in knowledge and to help inform the investigation and interviewing process e.g. around issues of mental health, drug and alcohol misuse, restraint.

Development of a more multi disciplinary approach to investigations on similar lines to the Prison Inspectorate would greatly aid the investigation process

E.g. with mental health/substance misuse experts forming part of the investigation/review team. Development days/training can be helpful in building up knowledge and skills base.

Failure to refer cases to the CPS

This is a common criticism in cases and highly contentious for families given the lack of visible accountability and justice. Recent experience also suggests some confusion about when and a case can be referred.

The IPCC could also benefit from earlier referral of contentious cases to the CPS for input into potential criminal aspects of the case, issues around choice of experts etc.

Investigation Report

Consultation on draft investigation reports

- Consultation with the family should be meaningful. Although families should be updated throughout the investigation, the report is not generally circulated and consulted upon before being finalised. Sean's family recall reading a draft around a table but not being allowed to have a copy. In contrast investigations reports prepared by the Prisons and Probation Ombudsman reports are initially circulated in draft form with an 8 week consultation period. This is important in identifying any issues that the family do not think have been adequately explored. This is also sometimes the first time that the family properly understand what the IPCC have been doing and an unrepresented family may decide at this stage to seek legal representation.

Poor standard of report writing

- Failure to test evidence or resolve conflicts and gaps in the evidence is common to many reports. It would be better for the report to acknowledge evidential conflicts or gaps and acknowledge these have not been possible to resolve rather than leave them without explanation. Such conflicts or gaps in evidence can also help inform the conduct of any inquest.
- Breakdown and evidential analysis of every contentious aspect of the case would be helpful. In Sean's case, the restraint and what took place in the back of the van were both enormously significant issues were largely glossed over by the IPCC.
- Detailed time lines/chronologies. This would be a useful way of exposing evidential gaps or conflicts around timing between the individual accounts. In Sean's case key disparities around timing of events which should have been exposed at the investigation stage did not come out until the inquest. For example, officers claimed to have attended Sean's hostel, ignorant of his identity, at a time when he was already collapsed at Brixton police station. This would also help in identifying those issues that

need addressing and resolving at the inquest. Sean's inquest was listed for 8 weeks as none of the contentious issues were properly explained or resolved as part of the IPCC investigation.

- Policies/protocols: All relevant legislation, policies and protocols (national and local) should be identified and considered as a part of the investigation. Reports should show detailed consideration of police action against those documents. If policies are inadequate, this should be addressed as a recommendation. In Sean's case, several local protocols were never obtained by the IPCC and indeed only became available a few weeks before the inquest, after FOI requests were made by Hickman and Rose on behalf of the family.
- Training: should be addressed with respect to all key features of the case e.g. mental health, restraint. This should include the identification of all training that has occurred, any refresher courses, a consideration of training materials, and an identification of any gaps or shortcomings.

IPCC Roles

There is a need to clarify the roles and responsibilities of the IPCC team including the role of commissioners to assert overall direction and management of an investigation. This is a crucial role given they sign off the investigation and its quality.

The role of the commissioner is routinely unclear. They have historically been distant characters, rarely seen by families. A complacent organisational culture built up with Commissioners not being seen to take a proactive approach to their role and rarely challenging of the investigators or IPCC lawyers. We are noticing a change with Commissioners taking up more of an authoritative presence in some cases but this seems to be driven by individuals rather than being part of the culture and practice of the organisation. Practice is inconsistent and still very varied between cases. It also seems too dependent on the individual Commissioner rather than subject to guidance and protocols. Although they ultimately hold overall control and management of the investigation, and hold the truly 'independent' role within the IPCC there is often little practical evidence of this. The senior investigator often appears to take the directing and presiding role.

Given that the Commissioner is intended to bring the safety net of independence (they cannot have previous employment in police service) their authority and management should be clear and visible throughout. This is crucial for the family and public. They also need to assert their authority with both investigators and IPCC lawyers.

IPCC material and disclosure

Common to most IPCC investigation are difficulties and delays with disclosure throughout the process, including ahead of inquest hearings. Selection of used and unused materials remains a contentious issue on most cases, with

large numbers of relevant evidence appearing in the unused material e.g. in Sean's case the IPCC handwritten notes of the initial meeting at Brixton appeared in unused materials and did not come to light until the inquest hearing.

In Sean Rigg's case, there was also a failure to retain important samples.

Training and Learning

General Training

- Training needs to encompass effective report writing, evidence and information gathering etc as well the opportunity to discuss and explore notions of discrimination, equality and diversity issues, stereotyping, myth and general cultural awareness.
- Staff require appropriate supervision to ensure that they can manage the boundaries of their role and retain their impartiality and professional objectivity in situations where they may feel pressurised from a range of interests – the police, the family, and the wider public to take a partial view.
- Who monitors and audits the performance and professional development of the IPCC? Is there an IPCC OFSTED and, if not, why not? This is too important a role not to require a set of minimum competences and standards as agreed by those who work for the IPCC with input from those who have had the misfortune of using the service.

Learning

- Consideration should be given to the development of specialisation across key areas to enable better learning and a more specialised approach e.g. mental health, restraint, drugs/alcohol etc. Regular development training days should take place.
- Organisational learning: how is learning captured from case to case? What mechanisms and systems are in place for increasing knowledge and expertise from case to case both individually and organisationally? Do de-brief sessions take place to consider what has worked/not worked, use of experts etc both for investigators, family liaison managers and commissioners? Even if in the initial period following set up the IPCC felt justified in drawing on the police model for its investigations, after more than ten years the organisation should be building its own systems of approach and expertise to respond and serve the needs of its distinct function and role. There is little evidence this is happening.
- There should be a more joined up cross sector/cross jurisdiction approach to help review and develop.
- Every death investigated by the IPCC should include a review of recommendations made previously by the IPCC following deaths raising similar issues and an audit of what action was taken in response.

External engagement and learning

- How is the IPCC raising issues externally? Where the IPCC reaches the limits of its powers (e.g. a Chief Constable refuses an IPCC request to suspend officers involved in a contentious restraint case or the problems with RIPA) to what extent if any is the IPCC calling upon external political structures to add weight to those issues e.g. informing the Policing Minister/Police Commissioners given the possible impact on public confidence in the local policing service? What systems are in place to ensure routine follow up of issues? To what extent is the IPCC being vocal on issues and concerns arising out of individual cases?
- The IPCC needs a more proactive role as a police oversight watchdog.

Post inquest work?

- Including recording of recommendations, verdicts and R 43s for learning and use in future investigations. Is there an interface between the fruits of investigations into complaints and deaths to identify any thematic issues concerning policing policies and practices?

Sustained learning of the policing institutions

- Mechanisms must be put in place for ensuring sustained learning. Whilst there is important learning from individual cases there is a significant role that the IPCC has in terms of examination of broader thematic issues raised by cases and issues pertinent to broader policy considerations on drug and alcohol use, mental health, policing, domestic violence etc. Current cases INQUEST is dealing with suggest that learning is not sustained. The fear is that shocking, contentious cases generate an immediate response and learning but that learning is not sustained and embedded and the same cycles/patterns repeat themselves. E.g., a deeply concerning example is the recent high number of deaths involving mental health and restraint, including the use of prone restraint, reminiscent of cases from ten years ago. The IPCC should be playing a central role in identifying those repeat patterns and concerns to ensure these issues remain a priority for sustained learning, training etc and drawing these thematic concerns to the attention of policy makers and Government. The IPCC has a unique role in terms of access to evidence about policing standards and an important guardianship role. It can demonstrate its independence and oversight role by drawing attention to systemic failures and flawed policies and practices alongside its investigative role.

Communication with families

Features of Sean's case, common to many family experiences of the IPCC relationship, included: early breakdown of trust, poor communication, embattled and often hostile communication, 'institutional defensiveness' which did not allow the family to raise important concerns and grievances, perceived

lack of professionalism to do the job properly and fairly, belief of collusion and cover up. The devastating experience of having a much loved relative die in custody was made all the worse by the experience of the IPCC investigation process.

Without faith that the IPCC are capable of exposing the truth in difficult and contentious cases like Sean's, families are forced into the role of investigators, at great personal cost.

There is a need for the IPCC to properly recognise and value the personal insight families bring to a case and an investigation. There need to be proper systems and mechanisms in place to ensure that families can say what they think without relations with the IPCC breaking down. Above all families want professionalism, and honest, direct communication.

The IPCC often display a misplaced defensiveness in the name of independence. There is a need for the IPCC to manage expectations without being obstructive. Systems and mechanisms are also needed to ensure the IPCC learn from family experiences as there are currently no family feedback arrangements in place.

It is important for the IPCC to recognise the difficulties and demands of the job to ensure the necessary internal training and support structures are in place to enable staff do to the job properly. Staff at the IPCC must be capable of dealing with emotionally fraught situations. There are too many examples of staff not coping: taking things personally, crying, becoming physically agitated, and struggling with communication.

There is a need for ALL staff working in the IPCC to have training on working with families following a death with the involvement of families who have personal experience of a custodial death and the investigation process.

Concluding comments

The IPCC is uniquely placed to scrutinise policing methods, techniques, operational policies and practices, and to consider whether the treatment and care afforded to the deceased was in violation of Article 2 and 3. Its potential in the identification of dangerous practices and systems and individual and systemic problems can act as an important safeguard in the protection of vulnerable people and improve custodial health and safety. Its role as a robust investigator where a death has occurred and in the identification of any wrongdoing by police is vital in increasing family and public confidence and in ensuring that justice is both done and seen to be done.

To this end the guardianship role of the IPCC is crucial in promoting 'excellence' in policing. The follow up of recommendations is crucial and yet the remit of the IPCC does not extend beyond the production of their investigation report and does not have the follow up of recommendations or

evidence that emerged during the inquest within its remit. It is vital that there is integration of investigation and inquest findings and follow up. This should ensure that findings and recommendations made as part of the IPCC investigation are integrated and that issues emerging in narrative verdicts/rule 43 reports that have both local and national learning are identified. At present the accountability void means that matters are in danger of disappearing into the ether. Even with the good practice of IPCC Learning the Lessons bulletins there is no systematic case by case timeline of actions taken in response to the individual death and how this impacts nationally. There is no framework in place to follow up what the response to the learning identified has been.

With a shift in culture, attitude and approach the IPCC could play a dynamic and crucial guardianship role in the oversight of policing and the upholding of policing standards. Whether this can take place remains to be seen.

Deborah Coles co-director
Vic McNally caseworker
INQUEST, January 2013

INQUEST has a proven track record in delivering an award-winning, free in-depth specialist casework service on deaths in state detention or involving state agents². It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. It monitors public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work. INQUEST undertakes research and develops policy proposals to campaign for changes to the inquest and investigation process. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring. Our casework service informs our research, parliamentary and policy work and we are widely consulted by government ministers and departments, MPs, lawyers, academics, policy makers, the media and the general public.

References

Learning From Death In Custody Inquests: A New Framework for Action and Accountability. Deborah Coles and Helen Shaw. INQUEST 2012

² This includes deaths in prison, in police custody, following police contact, fatal shootings by police, deaths in immigration detention, of detained patients and in secure training centres.