INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST evidence submission to the United Nations High Commissioner for Human Rights report on *"systemic racism, violations of international human rights law against Africans and people of African descent by law enforcement agencies, especially those incidents that resulted in the death of George Floyd and other Africans and people of African descent, to contribute to accountability and redress for victims"*

December 2020

Introduction

1. INQUEST Charitable Trust is an independent non-governmental organisation which provides expertise on state-related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

2. Our specialist casework with bereaved families focuses on deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as Hillsborough and the Grenfell Tower fire. INQUEST works primarily in England and Wales, and advises on a small number of cases in Scotland. We have also shared our expertise on the investigation of state related deaths and the treatment of bereaved people at an international level.

3. Over the past 40 years, INQUEST has advised and assisted countless bereaved families, including many families bereaved by deaths in contact with the police. As a result, we have a unique overview of the investigatory processes, the treatment of bereaved people and the issues arising from these deaths. We have worked consistently to strengthen the institutional framework for accountability for deaths in all forms of state detention and how this works in pursuit of goals of truth, justice and accountability for bereaved families.

4. INQUEST's evidence draws from our involvement, alongside bereaved families, in many national reports and reviews that address directly or indirectly issues of racism in law enforcement and detention. INQUEST's Executive Director Deborah Coles acted as a Special Advisor to the recent *Independent review on deaths and serious incidents in police custody* chaired by Dame Elish Angiolini QC, and has advised on many other official reviews. She currently sits on the cross government sponsored Ministerial Board on Deaths in Custody, and is a member of the Independent Advisory Panel on Deaths on Custody.

5. INQUEST's evidence has informed numerous UN human rights bodies, including the Working Group of Experts on People of African Descent, the Committee against Torture, Subcommittee on Prevention of Torture. We appreciate this opportunity to provide evidence to OHCHR to support preparation of its report pursuant to Human Rights Council resolution 43/1 on the "Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers".

6. Our evidence focusses on three main areas of the call for inputs, as indicated below.

Policies and practices that give rise to, perpetuate, entrench and/or reinforce systemic racism, racial discrimination and associated human rights violations against people of African descent

7. Our experience working on cases of state violence and deaths in custody makes clear that these shed light on longstanding, deeply-rooted structural racism. These cases must be examined in light of the broader social, economic and political context of policing, imprisonment, immigration, health and legal systems in maintaining and exacerbating racial inequalities and discrimination against Black people.[1] We indicate here some of the key evidence that demonstrates these in the context of law enforcement.

- According to a recent survey, 85% of Black people in the UK do not believe that they would be treated the same as a white person by the police.[2]
- In 2019/2020 Black people were 8.9 times more likely than white people to be stopped and searched by police in England and Wales.[3] This has been exacerbated during recent months and the entry into force of the Coronavirus Act 2020, since when the number of Black people being stopped and searched by the police has increased dramatically, and disproportionately compared to white people.[4]
- In 2019/2020 Black people were five times as likely to have force used against them by police as white people and were subject to the use of Tasers at seven times the rate of white people.[5]
- Deaths of Black people by fatal shooting account for 18.6% of all police fatal shooting deaths between 2004/5 and 2019/20.[6]
- INQUEST's data shows that although the numbers of deaths of Black, Asian and minority ethnic (BAME) people in police custody or following contact with the police have been proportionate to the population as at the 2011 census (14%), people of Black, Asian and minority ethnicity die disproportionately as a result of use of force or restraint by the police.[7] This is particularly an issue for people from Black African and Caribbean descent.

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[1] In this submission we use the term Black people instead of people of African descent as this is the language most commonly used in the UK. We sometimes use "BAME" which is commonly used to refer broadly to Black, Asian and minority ethnic people, though we use this only as a category when it is not possible to break down into specific groups.

[2] Joint Committee on Human Rights (2020) Black people, racism and human rights: Eleventh Report of Session 2019-21 https://committees.parliament.uk/publications/3376/documents/32359/default/

[3] Ministry of Justice (2020) Stop and Search https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2020

[4] The Metropolitan Police Service carried out just under 42,779 stop and searches during May 2020. 16,482 (39%) of the searches were carried out on Black males and 14,210 (33%) on White males. These figures equate to a rate of 27.6 per 1,000 population for Black males compared to a rate of 5.9 per 1,000 population for White males. The Metropolitan Police Service, Stop and Search Dashboard as cited by the Joint Committee on Human Rights (2020) Black people, racism and human rights: Eleventh Report of Session 2019-21 https://committees.parliament.uk/publications/3376/documents/32359/default/

[5] Home Office (2020) Police use of force statistics, England and Wales: April 2019 to March 2020 https://www.gov.uk/government/statistics/police-use-of-force-statistics-england-and-wales-april-2019-to-march-2020

[6] IOPC (2020) Deaths during or following police contact: Statistics for England and Wales Time series tables 2004/05 to 2019/20 https://policeconduct.gov.uk/sites/default/files/Documents/statistics/Time_series_tables_2019-20.ods

[7] INQUEST is currently updating its data to further disaggregate this data to ethnic background.

- The proportion of BAME deaths in custody where restraint is a feature is **over two times** greater than it is in other deaths in custody.
- The proportion of BAME deaths in custody where use of force is a feature is **over two times** greater than it is in other deaths in custody.
- The proportion of BAME deaths in custody where mental health-related issues are a feature is **nearly two times** greater than it is in other deaths in custody.

8. More widely, there is a continuum of racial inequalities that are aggravated in state custody and detention.

- In 2018/2019 known rates of detention under the Mental Health Act for Black or Black British people were four times higher than for white British people.[8]
- People of Black, Black British, Black African and Black Caribbean ethnicity and those of mixed ethnic heritage are proportionately more likely to be subject to the use of force in mental health settings than other ethnic groups.[9]
- As of June 2020 7.7% of the prison population[10] were Black despite the comprising 3.4% of the population in England and Wales.[11] The number of children from a Black background in youth custody accounts for 28% of the youth custody population, an increase of 13% over the past ten years.[12]
- The use of remand to prison is more pronounced for Black women than white women. In magistrates courts in 2019, 59% of white women remanded in custody did not go on to receive an immediate prison sentence, compared with 73% of Black women.[13]
- Black and minority ethnic prisoners report a more negative experience than white prisoners about most areas of prison life and report feeling marginalised and that staff failed to challenge inappropriate or racist behaviour.[14]
- The data on use of force in prisons is not centrally collated so a national picture cannot be reported. However, evidence from local data suggests there is disproportionality in the number of use of force incidents against Black men across the estate, especially younger Black men.[15]

[8] Care and Quality Commission (CQC) (2019) Monitoring the mental health act https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf
[9] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report
[10] Ministry of Justice (2020) Prison Population: 20 June https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2020--2
[11] According to the 2011 National Census https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest#by-ethnicity
[12] Ministry of Justice (2020) Youth Justice Statistics https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf
[13] https://www.gov.uk/government/statistics/criminal-justice-system-statistics-quarterly-december-2019
[14] HM Chief Inspector of Prisons for England and Wales Annual Report 2018-2019 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/07/6.5563_HMI-Prisons-AR_2018-19_WEB_FINAL_040719.pdf
[15] HMPPS (2019) Equality Analysis, Use of Force http://www.prisonreformtrust.org.uk/Portals/0/Documents/PAVA/Use%20of%20Force%20Equality%20Analysis.pdf; further demonstrated in a report by Runnymede and the University of Greenwich (2017) which analysed the use of force data at one adult prison and found it was much higher amongst those of Black ethnicity *(5.4 per 100 amongst Black prisoners compared to 1.7 per 100 White) (p23)*

- There have been 57 of deaths of immigration detainees since 2000, of which over one third (22) have been of Black African, Black Caribbean or other Black ethnicities.[16]

Specific incidents of alleged violations of international human rights law against Africans and people of African descent by law enforcement agencies

9. INQUEST's casework and monitoring shows that the disproportionate number of Black people who die after the use of lethal force and neglect by the State comes at the sharp end of this continuum of racialised state harm and violence. These deaths connect with the Black community's experience of structural racism, over-policing and criminalisation.

10. Through an analysis of our casework INQUEST has identified that the racial stereotype of 'big black and dangerous', 'violent' and 'volatile', when woven into the culture and practice of the police, has been a reoccurring feature deaths following use of force and restraint by police in the UK. In cases where people have had mental health needs, additional negative imagery and stereotyping – 'mad, bad and dangerous' – has informed their treatment: we are particularly concerned about the double discrimination experienced by Black people with mental health issues.[17]

11. We consider here six emblematic cases of Black men who have died, illustrating issues around (a) mental ill health and restraint, and (b) excessive use of force and violence which are broader themes of concern across our work. Additional cases are referred to later in the submission. Despite the work of the government's *Independent review on deaths and serious incidents in police custody*, published in November 2017, there have been a further six deaths of Black men during police contact, three of which feature restraint. We also highlight the case of one Black woman who died in prison, whose treatment by police illustrates these issues further.

Mental ill health and restraint

12. **Sean Rigg, 40** died of a cardiac arrest following an eight minute prone restraint by Metropolitan Police officers in 2008 when he was experiencing a mental health crisis[18]. In 2012 the inquest jury found that his death was contributed to by a litany of failures, including that police 'failed to identify that Sean was a vulnerable person at point of arrest' and take him to an Accident & Emergency department rather than a police station. An officer involved in Sean's arrest was captured at the custody desk saying *"I hope he hasn't got anything, I've got his blood on me"* and *"he's faking it"*.[19] When Sean was eventually carried out of the van he was shown to be slumped and unresponsive. In this case, as in others, a racialised fixation on dangerousness by law

[16] INQUEST casework and monitoring 2020
[17] Evidence of INQUEST Director Deborah Coles to the UN Regional Meeting on the International Decade for People of African Descent, 2017: https://www.ohchr.org/Documents/Issues/Racism/WGEAPD/RegionalMeetingEurope/Deborah%20Coles%20Paper%20-%20JUSTICE.pdf
[18] Jury condemns actions of the police and mental health trust in verdict over death of Sean Rigg (2012)https://www.inquest.org.uk/sean-rigg-inquest-opens
[19] Nina Lakhani (2012) The story behind Sean Rigg's death in custody https://www.independent.co.uk/news/uk/crime/story-behind-sean-rigg-s-death-custody-7999485.html

enforcement personnel meant they failed to consider his welfare and safety. A jury at his inquest concluded whilst in custody '*the police failed to uphold [Sean's] basic rights and omitted to deliver the appropriate care'* and that restraint in the prone position was *'unnecessary'* and *'unsuitable'*.

13. **Olaseni (Seni) Lewis, 23,** died in 2010 a mental health unit where he was a voluntary patient. Multiple failures at multiple levels meant hospital staff called on the assistance of the police when Seni became unwell: his death followed two successive periods of prolonged restraint by 11 Metropolitan Police officers. At the inquest into his death in 2017, the jury found that the use of restraint, which included the use of mechanical restraints, was found to have *been excessive, unreasonable, unnecessary, disproportionate and contributed to his death.*[20] The jury concluded that there was a failure on part of the hospital staff and police officers alike to provide basic life support when he collapsed under restraint. Racist and dehumanising stereotypes were employed by police officers to defend their actions during the inquest: *"We didn't immediately call a doctor [when he became unresponsive] because we weren't 100 per cent sure if he was definitely unconscious or not breathing. We left the room in case he was feigning, passing out as a ploy to escape."*

14. **Kevin Clarke, 35,** died in 2018 following restraint by Metropolitan Police officers whilst experiencing a mental health crisis. At the inquest into his death, which concluded in October 2020, the jury found system-wide failures by the ambulance, mental health, and police services and assisted living provider possibly or probably contributed to his death.[21] In particular, they found that police officers' decision to use restraint was inappropriate because it was not based on a balanced assessment of the risks to Kevin, compared to the risks to the public and police. Kevin was generally cooperative and responsive up until the point when officers laid hands on him, the jury found, and opportunities for earlier, less restricted intervention were missed by the mental health trust and assisted housing provider. During the restraint, which lasted 33 minutes, Kevin told officers *"I can't breathe"* and *"I'm going to die"*, but they said they did not hear him. Despite this, the jury concluded that it was 'highly likely' that at least one officer heard Kevin say *"I can't breathe"*.

15. The inquests into all three deaths highlighted the collective failures of the police and mental health services to respond to individuals in distress. At times the language used by police or health professionals, who owed Sean Rigg, Seni Lewis and Kevin Clarke a duty of care, was dehumanising. It is particularly important to note that all three individuals were under the care of the same mental health provider and were restrained by officers from the same police force. The fact that these three deaths could occur over a period of 10 years illustrates the failure of accountability processes to force the changes needed to prevent deaths.

16. In the cases of Sean and Kevin, opportunities were missed for mental health services to intervene at the point that there were warning signs of potential relapse, and as a result the police were called to intervene. These cases highlight why it is so important

[20] Jury condemns police restraint of young black man in mental health hospital whilst medical staff looked on (2017)https://www.inquest.org.uk/seni-lewis-conclusion
[21] Jury find system wide failures contributed to death of Kevin Clarke (2020)https://www.inquest.org.uk/kevin-clarke-close

to end the reliance on police as the first responders to health emergencies and why we have repeatedly highlighted the urgent need for structural and cultural change in policing, mental health and healthcare services. Consideration should be given to establishing 24/7 mental health emergency response units to replace the role of police.

Excessive use of force and violence

17. Other cases of where Black men have died in contact with the police have presented a disturbing picture of violence and excessive use of force by the police which was used as a first, not last, resort. We illustrate some of these cases here.

18. **Darren Cumberbatch,** 32, died in 2017 after he was restrained by seven Warwickshire police officers, during which he experienced baton strikes, other physical strikes, multiple punches, stamping, PAVA spray and three discharges of Tasers, all inside a small toilet cubicle.[22] The jury at the inquest found that inadequate de-escalation attempts were made by the police, that the use of force was at times excessive and that the police's restraint contributed to his death. His medical cause of death was multiple organ failure as a result of cocaine use in association with restraint and related physical exertion.

19. **Sheku Bayoh** died aged 31 following restraint by five police officers in May 2015 in Kirkcaldy, Scotland. Sheku was stopped by police after they received a call about a man behaving unusually. Within 46 seconds of the arrival of the first two offices, he was held face down on the ground. During the restraint, officers used CS and PAVA spray, batons, leg and ankle restraints and handcuffs and he was held face down. It is also alleged that two of the police officers involved and placed their full body weight on his upper body. He was unconscious within minutes of the restraint being applied and was pronounced dead at the hospital an hour and a half later. A post-mortem revealed that he sustained facial injuries, bruises to his body and a fracture to his rib. Four and a half years after his death, and as a result of concerns about the investigation of his death, the Scottish Government announced a public inquiry into his death which is ongoing.[23]

20. **Mark Duggan,** 29 was killed by a firearms officer in 2011 during a police surveillance operation. The taxi Mark was travelling in was stopped as a result of 'intelligence' he was carrying a gun. The inquest into Mark's death concluded he was lawfully killed despite finding that he was unarmed at the time.[24] Recent independent forensic investigations[25] have cast doubt into official accounts of the shooting, particularly the finding by the police monitoring body, the Independent Police Complaints Commission (IPCC) that Mark was holding or throwing away a gun. The IPCC investigation was subject to serious criticism over its quality and robustness after the Metropolitan police service were uncooperative, with the officers refusing to be interviewed.[26] Mark was from Tottenham in London, a community at the sharp end of police harassment

[22] Jury finds restraint my Warwickshire police contributed to death of Darren Cumberbatch (2019) https://www.inquest.org.uk/darren-cumberbatch
[23] Scottish Government announce public inquiry into the death of Sheku Bayoh (2019) https://www.inquest.org.uk/sheku-bayoh-inquiry
[24] Jury in Mark Duggan inquest concludes he did not have a gun in his hand when he was shot (2014) https://www.inquest.org.uk/jury-in-mark-duggan-inquest-concludes-he-did-not-have-a-gun-in-his-hand
[25] Forensic Architecture (2020) The Killing of Mark Duggan https://forensic-architecture.org/investigation/the-killing-of-mark-duggan
[26] Inquest into police shooting of Mark Duggan opens https://www.inquest.org.uk/mark-duggan-inquest-opens

and previous police related deaths and his death ignited frustration and anger and saw widespread disturbances spiral across UK in 2011.

21. Our concerns about excessive use of force were brought into sharp focus in the summer of 2017, where over a one-month period between 21 June to 22 July, there were four restraint related deaths of young Black men; Edson Da Costa, Darren Cumberbatch, Shane Bryant and Rashan Charles.

22. INQUEST has also reported concerns about the role racism has played in the treatment of Black women who have died in prison and mental health settings, with their calls for healthcare being disbelieved or their disturbed behaviour being treated as a discipline and control problem.[27] **Sarah Reed,** a black mixed race woman, had been a victim of police brutality four years before she died. She was found with a ligature around her neck, at HMP Holloway prison in 2016 aged 32. The assault by a police officer, captured on camera,[28] showed Sarah being punched, thrown to the ground and restrained after being caught shoplifting. This experience aggravated her mental ill health. At the time of her death, Sarah was on remand solely for the purpose of obtaining two psychiatric reports to confirm whether she was fit to plea for an alleged offence which took place whilst she was a sectioned inpatient at a mental health unit. When in prison much of her increasingly disturbed behaviour was interpreted by prison staff as a discipline issue. The inquest jury were highly critical about her treatment.[29]

23. The deaths of these seven individuals connect with the black community's experience of structural racism, over-policing, criminalisation and neglect. They have provoked public, parliamentary and community disquiet, and their impact on police and community relations has been profound. INQUEST views these cases not as isolated individual tragedies, as some have sought to portray them, but part of a systemic problem of racialised harm, ill treatment and violence.

The outcomes and effectiveness of measures to ensure accountability, remedy and redress and address any impunity against people of African descent, particularly by law enforcement agencies (including the functioning of accountability mechanisms and any patterns/trends in the outcomes that show differential experience of people of African descent)

24. The UK has one of the most developed frameworks for oversight of places of custody and detention, which includes systems for investigating deaths where these occur. The development of these frameworks has been informed by Article 2 of the European Convention on Human Rights, incorporated into UK law by the Human Rights Act.

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[27] Deborah Coles (2019) Failing healthcare in jails is killing female prisoners https://www.theguardian.com/commentisfree/2019/apr/05/healthcare-jails-killing-female-prisoners-black-women-annabella-landsberg; INQUEST (2018) Still Dying On the Inside: Examining deaths in women's prisons https://www.inquest.org.uk/still-dying-on-the-inside-report

[28] Woman assaulted by PC who lost his job found dead in Holloway Cell https://www.theguardian.com/society/2016/feb/03/sarah-reed-assaulted-by-pc-dead-holloway-prison

[29] Jury concludes unnecessary delays and failures in care contributed to death of Sarah Reed at Holloway prison https://www.inquest.org.uk/sarah-reed-inquest-conclusions

25. In England and Wales, the inquest system is the primary means by which the state discharges the duty to investigate deaths, including deaths in custody. An inquest is a legal process which seeks to determine the circumstances surrounding a death, when and how someone died. Aspects of the inquest process have been influenced heavily by the procedural obligations of Article 2 which have broadened the scope of inquests into deaths where there may have or has been a breach of the duty to protect life.

26. With respect to law enforcement, the Independent Office for Police Conduct (IOPC)[30] is the independent statutory body set up to make the police more accountable to the public, and is tasked to investigate all deaths in or following police custody in the 43 police forces in England and Wales. IOPC reports and evidence are provided to the coroner to inform the inquest into these deaths. It is important to note that the IPCC, the precursor to the IOPC, was set up as a direct result of the disquiet over a number of high profile deaths and the lack of any independent police complaints system. The IOPC therefore has a significant institutional responsibility to maintain public confidence, and restore it where it has been lost. However, as we have recently reported to the Home Affairs Select Committee, many bereaved families are concerned that the IOPC lacks independence and as we will illustrate in this submission, there are many significant questions about the extent to which the IOPC achieves accountability. In 2020, the United Friends and Family Campaign, a coalition of those affected by deaths in police and other forms of custody, called for the abolition of the IOPC in order to replace it with a *"truly"* independent body that can conduct robust and transparent investigations into police involved with deaths.[31]

27. Following an investigation by the IOPC, a matter may be referred to the Director of Public Prosecutions if there is an indication that a criminal offence may have been committed by a subject of the investigation. The CPS then consider whether criminal charges should be brought against any of the subjects of the investigation.

28. Alongside these, police custody is subject to two layers of independent monitoring, one by volunteers (Independent Custody Visitors, ICVs) and the second by an independent inspectorate (HM Inspectorate of Constabulary and Fire & Rescue Services, HMICFRS) that inspects and reports on all aspects of policing.[32] Both are members of the UK's National Preventive Mechanism and so hold responsibilities to prevent torture and ill treatment in line with UN standards.

29. In spite of all of these, as we explain in this submission, accountability is too often a hollow concept, with failures, mistakes, ill-treatment and abuse repeating time and time again, and those responsible rarely held to account.

30. An effective system for police accountability depends on more than those bodies specifically set up to scrutinise the police, in our case the IOPC and HMICFRS. In our experience, there has been insufficient attention on the crucial role of the Crown Prosecution Service and the police themselves, who too often hold up, fail to cooperate with and even actively undermine processes to ensure accountability.

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[30] Formerly the Independent Police Complaints Commission (IPCC)
[31] Racism campaigners call for police watchdog to be abolished (2020) https://www.theguardian.com/uk-news/2020/jun/14/racism-campaigners-iopc-police-watchdog-abolished
[32] Independent Custody Visitors Association https://icva.org.uk/about/ and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services https://www.justiceinspectorates.gov.uk/hmicfrs/about-us/

31. Furthermore, where accountability mechanisms do produce recommendations for systemic change, as is the case in outcomes of inquests, investigations and wider reviews and inquiries, of which there have been many, these must lead to concrete action. INQUEST has evidenced a shameful failure to enact meaningful systemic change in line with these recommendations. Time and again, we have seen that that following failures of the state and its agents and contractors to respect the right to life of Black people and the right to live free of discrimination, the very mechanisms established to provide accountability and justice have failed to make real these concepts in any meaningful terms, or to challenge the structures that keep racial inequalities and racialized harm so deeply embedded in our society.

32. We explore below in turn some specific areas of concern for INQUEST and the bereaved families we have supported. Many of these apply broadly to any families who have lost loved ones after police contact.

Addressing race and racism

33. Historically there has been a lack of understanding by the IOPC, and its precursor the IPCC, of broader themes around race, particularly in restraint-related deaths of Black men. Cases are looked at in isolation without due attention to the learning from previous deaths where there may have been similarities in the response by police or other services. If questions of racial stereotyping or racism are examined in isolation in relation to each individual case, it will be hard if not impossible to establish clear discrimination. Instead the impact of racist stereotyping – which we are concerned has clearly been a contributory factor in some of the cases we have seen – only emerges when the wider picture spanning a range of deaths and other non-fatal incidents is considered. Evidence of racial stereotyping by the Metropolitan Police led to the most damaging censure of the police when the 1999 Macpherson public inquiry attributed the bungled police investigation into the racist murder of Stephen Lawrence to institutionalised racism. Despite this, to this day, the question of racism remains the 'elephant in the room' neither part of the investigation process nor inquest. The review by human rights expert Silvia Casale following the investigation into the death of Sean Rigg highlighted this very issue:[33]

"The lack of reference to race throughout is not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately." Silvia Casale

34. As the Angiolini review made clear, where there is evidence of racist or discriminatory treatment or other criminality or misconduct, police officers must be held to account through the legal system. Failure to do so undermines community confidence in the police and is damaging to police and community relations.

35. We welcome the IOPC's recent announcement that they will be "launching race discrimination as a thematic area of focus to establish the trends and patterns which

[33] Report of the independent external review of the IPCC investigation into the death of Sean Rigg (2012) https://www.seanriggjusticeandchange.com/Review%20Report%20FINAL.pdf

might help drive real change in policing practice" but await the results of this work and are not sure how much it involves bereaved families and others affected.[34]

36. The failure to examine racism or discriminatory treatment directly in accountability processes reaches far wider than police investigations and inquests.

37. It took pressure from INQUEST with others, for example, to ensure that the terms of reference for the Sheku Bayoh inquiry in Scotland included a specific focus on the role race may have played in his death, considering the ample evidence about the disproportionality of Black men dying after restraint.[35] This is a problem that extends beyond policing: INQUEST has repeatedly called for a specific focus on institutional racism and discrimination in the Grenfell Inquiry, yet this has not been taken up.[36]

38. Finally, we are concerned that the deeply rooted patterns of disproportionality and discriminatory treatment have become too easily accepted as a given. It is a travesty that despite the scale of these issues and their daily impact on the experience of Black people they do not invite greater censure or accountability. For example, the most recent inspection report of Metropolitan Police custody by HMICFRS and NPM partners identified that while the police force collated data relating to 'diversity' in custody, it was unclear how this data was used. It concluded: "It was not clear how the force could demonstrate how it met the public sector equality duty for custody and that it treated all detainees fairly and equitably".[37] We have not been able to find any evidence of the Met's response to this suggestion that legal duties may have been undermined, nor any evidence of how the inspectorate has followed up to ensure action is taken to address this situation.

Timeliness and delays

39. Bereaved families frequently raise their concern about the inordinate length of time they have to wait for decisions and answers at each stage of the post death investigation processes. In some cases, a family's journey for truth, justice and accountability can stretch a decade - especially when multiple public bodies are involved.[38] Our concerns about delays are relevant across all police death cases, but given that a number of the most complex or contested cases involving restraint relate to Black men, these concerns are particularly relevant to their cases.

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[34] IOPC announces thematic focus on race discrimination investigations (2020) https://policeconduct.gov.uk/news/iopc-announces-thematic-focus-race-discrimination-investigations

[35] Specifically, "to establish the extent (if any) to which the events leading up to and following Mr Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard" https://www.parliament.scot/S5_HealthandSportCommittee/General%20Documents/20200521CSJtoMMSheku_Bayoh.pdf

[36] Grenfell Tower Inquiry Recommendations (2020) https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=2912cd8c-826a-4186-84c5-318443637a29

[37] Report on an unannounced inspection visit to police custody suites in Metropolitan Police Service by HM Inspectorate of Prisons and HM Inspectorate of Constabulary and Fire & Rescue Services (justiceinspectorates.gov.uk) para 1.16 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/01/Metropolitan-Police-Service-Web-2018.pdf

[38] In the England and Wales context, these commonly include the Crown Prosecution Service, the police, the Health and Safety Executive and the coroner.

40. There are many stages where delays in the process of investigating deaths commonly occur and these cause great frustration and pain to bereaved families as well as generating mistrust of the bodies involved in the investigation processes. We have seen cases where investigators are too slow to arrive to be able to gather essential evidence from the scene, or evidence going missing or not seized. We have also observed recurring failures to carry out prompt interviews with officers and witnesses. This causes delay in investigation processes, potentially weakens evidence, and undermines families' confidence in the investigation. For example, during the investigation into the death of Rashan Charles, who died following police restraint in 2017, the officer that was instrumental in the restraint was not interviewed until five months after the incident.

41. As we recently highlighted to the Home Affairs Select Committee, delays in accountability are often a result of the slow decision-making by the Crown Prosecution Service. It is not uncommon in police death cases for the CPS to take many months, and sometimes years, to make a decision around prosecution. There is typically a complete halt to disciplinary and other processes while the CPS decision remains outstanding. So for example, a police force professional standards department routinely delays disciplinary proceedings and a coroner routinely adjourns any inquest until the CPS has taken its decision. We have often seen inquests where as a result of delays, suspects and witnesses are likely to say that they cannot remember details or answer certain questions and inevitably this assists in creating a doubt in the minds of the jury. The impact of these delays on complainants, bereaved families, police officers, and public confidence is significant. It severely frustrates the learning and accountability processes.

"It is unfair to wait five years before an inquest is held, with officers being questioned stating they can't remember what happened. Investigations should be concluded within a short time period, keeping families informed and keeping the same investigating team, ours kept changing all the time." – Anonymous bereaved family member

42. Where multiple public bodies play a role in investigating deaths in police custody or following police contact, as is the case in England and Wales, it is crucial that these bodies work together from the outset, and where possible investigations proceed in parallel, to avoid delays. This was a matter considered in depth in the Angiolini Review into deaths and serious incidents in police custody, who recommended greater cooperation and consultation between organisations involved from the very early stages and regularly throughout any investigation.[39]

[39] Report of the independent review of deaths and serious incidents in police custody, Rt. Hon. Dame Elish Angiolini DBE QC, key findings paragraphs 26-28. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

The timeline following the death of Leon Briggs, 39, a Black man who died in 2013 whilst detained under the Mental Health Act following restraint by police officers, exposes a trajectory of failures and delay in the post death investigation processes.

- **November 2013:** Leon Briggs, died in police custody whilst detained under the Mental Health Act after being restrained by Bedfordshire police officers.
- **March 2016**: The Independent Police Complaints Commission (IPCC, now the IOPC) referred the case to the Crown Prosecution Service (CPS) for a decision on whether criminal charges should be brought, following their investigation into the circumstances of Leon's death.
- **September 2018**: CPS confirmed no charges would be brought following Leon's death.
- **February 2020**: The IOPC withdrew directions to bring gross misconduct proceedings for five officers after Bedfordshire police force said they would not present any evidence against its officers.
- **January 2021**: The inquest is to open into Leon's death, over seven years since he died.

43. Equivalent delays do not exist in the context of other types of misconduct and criminal investigations. These excessive delays at every stage adds an unacceptable burden on families, who without answers are unable to grieve properly and move forward with their lives. Timeframes should be clearly laid out, accounts from officers and witnesses must be obtained as early as possible and investigations by different bodies should proceed without delay and in parallel.

Conduct of the state

44. Through our experience working with the families of Black people who have died after contact with the State we have identified a number of areas where the conduct of the state plays a role in limiting accountability and perpetuating impunity.

45. **Police cooperation in investigations**. Too often we see the effects of the lack of cooperation and candour of police officers, who in the majority of cases are perceived to be reluctant to be interviewed by the IOPC. The IOPC has consistently failed to penalise the silence of such officers, which it could easily do by shifting the burden of proof onto officers to justify their actions when they refuse to answer questions. For bereaved families, this goes to the heart of the issue of independence and their impression that police officers are treated differently to other citizens. We are also concerned that the efficacy of IOPC investigations is frequently undermined by the absence of candour shown by police officers under investigation. It is common for IOPC investigations to face significant delays while officers under investigation are interviewed, only for the officers to give 'no comment' interviews, occasionally accompanied by a short written statements.

46. **Adversarial conduct at inquests.** INQUEST has long documented the adversarial nature of inquests, which for too many families are painful, stressful and deeply

frustrating. The inquest can be a vital process for families to find out why their loved ones have died, and in preventing future deaths, but too often they can have a re-traumatising impact. At some of the more complex inquests we have a culture of delay, denial and defensiveness by the state, with their lawyers resorting to tactics to deflect attention from and defend the reputation of the police. In cases where the deceased is Black, we have seen attempts by police officers and their counsel to deliberately discredit the deceased or family members by drawing on drug and 'gang' narratives. This was a tactic used by the police barristers at the inquest into the death of Rashan Charles. Rod Charles, Rashan's great uncle, observed:[40]

"We spent many hours in the inquest talking about Rashan's lifestyle, and a caricature was created of him as a major organised criminal. [the police barristers] spent an equal amount of time presenting Hackney as a no-go area. Guns and knives and police at risk if they deploy in that area. Hackney has challenges. So do many parts of London. But the barristers know why they chose to distract attention - to create a Rashan which isn't the true Rashan, to create Hackney which in not a true Hackney."

47. **Treatment of bereaved families and other witnesses.** Bereaved families tell us that instead of the death of their loved one being investigated, they have felt that during post death processes it was their private life and that of their relative that was subject to the most scrutiny. They have experienced attempts to demonise the person who has died, introduce racist narratives or build up a negative reputation, which creates the idea of an "undeserving" victim. All of this deflects attention away from official incompetence, criminality or wrongdoing with misinformation. For example, at the inquest into the death of Edson Da Costa, who died in 2017 after being restrained by police during a stop and search[41], the questioning of witnesses at the inquest was at times very aggressive. When the police barrister was questioning a friend of Edson's, who was a passenger in the car when it was stopped by the police, he sought to blame the friend for Edson's death. The police barrister said: *"You contributed to the circumstances that led to his death, didn't you?"*[42] At the inquests of Edson Da Costa and Rashan Charles, there was a police van and sometimes additional police cars – parked outside the venue which created a hostile environment for family members as they arrived and left the inquest. It should also be noted that before jurors were sworn in at the inquest into the death of Edson Da Costa, they were asked whether they or close relatives had been linked to campaign groups such as Black Lives Matter.[43]

"The narrative from the beginning is racist, right from the get-go. They look for things to demonise your loved one. They try to get out a narrative to the press that is demonising, its racist, its dehumanising. That is their agenda" - Anonymous family member

[40] Accidental death of a young Black Londoner the case of Rashan Charles https://www.opendemocracy.net/en/shine-a-light/accidental-death-of-a-young-black-londoner-the-case-of-rashan-charles/

[41] Jury concludes death of Edson Da Costa following restraint by Metropolitan Police was misadventure https://www.inquest.org.uk/edir-da-costa-inquest-concludes

[42] Edson Da Costa inquest: Young father's ID found with 12 inch zombie knife in car, police claim (2019) https://www.newhamrecorder.co.uk/news/crime/edson-da-costa-inquest-3216130

[43] Jurors were also asked if they or close family members had ever been employed by the police. See: https://www.essexlive.news/news/essex-news/edson-da-costa-death-man-2841763 and https://www.theguardian.com/uk-news/2020/nov/29/what-really-happened-to-edson-da-costa

"His character is completely destroyed and that's what they do. Instead of looking at what the police have done all the police background, they are busy looking at what my son's done and its them that have killed him" - Anonymous family member

48. **Anonymity orders.** INQUEST's casework and monitoring points to a concerning number of cases where police officers have requested to remain anonymous at inquests and in misconduct hearings. Anonymity has typically been granted for police officers following fatal shootings, but increasingly we see anonymity being requested in other circumstances, such as where a death involved restraint. We are aware of four cases since 2017 where anonymity has been granted, three of which relate to deaths of Black men. At the inquest into Rashan Charles, two officers and two witnesses were granted anonymity. At the inquest into Edson Da Costa, the police requested anonymity and ciphers for their officers, alleging among other grounds that they were at risk of reprisals as there had been BLM protests following Edson's death. Police officers gave their evidence from behind a curtain and only the family members who were willing to give details of their name, address, date of birth and occupation, and to undergo a check against the Police National Computer, were allowed to see them. Anonymity goes against the spirit of an open and transparent investigation and hinders scrutiny of public officials.

49. **Attempts by the police to undermine accountability processes.** We are particularly concerned by the role played by police forces and other police stakeholders in attempting to undermine the very accountability processes on which their legitimacy depends. One recent example of this was in the Court of Appeal case concerning the fatal shooting of Jermaine Baker by a Metropolitan police officer.[44] The IOPC made a commendable attempt to ensure the officer faced disciplinary proceedings for an allegation of objectively unreasonable lethal force. This was resisted not only by the officer himself, but by the Metropolitan Police Service (MPS) and the National Police Chiefs' Council (NPCC). Indeed, the MPS and NPCC sought to persuade the Court to adopt an interpretation of the Standards of Professional Behaviour that would have weakened police accountability for use of force in all cases in England and Wales. The 2020 decision of the Court of Appeal overturned a previous High Court decision, meaning that the officer should face proceedings for gross misconduct,[45] but we understand he has now applied for permission to appeal to the Supreme Court.

Access to justice and meaningful participation

50. A key challenge for bereaved families is the failure of the state to provide automatic non means tested legal aid for them to be represented by lawyers at inquests. It is important to note that this was a recommendation of the Stephen Lawrence Inquiry which laid bare the problems of institutional racism in the Metropolitan Police in a seminal report in 1999.[46] To this day, the recommendation remains particularly relevant to the cases we have set out above. The failure to provide automatic legal aid comes in stark contrast to the fact that state bodies automatically receive legal

[44] R(W80) v IOPC [2020] EWCA Civ 1301
[45] Court of Appeal reject police attempts to weaken accountability for use of force https://www.inquest.org.uk/coa-jermaine-baker
[46] Recommendation no.43, '*consideration [to] be given to the provision of Legal Aid to victims or the families of victims to cover legal representation at an Inquest in appropriate cases*'

representation at inquests, at taxpayers' expense, without any merits or means test. Often this can involve multiple state bodies being represented. This causes a fundamental inequality of arms: families are forced to take part in a process that they have not chosen to initiate, which will take place whether they are able to participate effectively or not, and which affects them more profoundly than any other participant. It cannot be right that effectively, a bereaved family whose loved one has died in the care of the state or after the state has used force, and it is left to them to pay to find out what happened.

51. It should also be noted that the provision of legal aid should ensure a more level playing field between legally represented parties. For example, at the inquest of Edson Da Costa:

"The five officers were represented by leading and junior counsel and the Metropolitan Police Commissioner had her own separate leading and junior counsel. However, as is often the case in such circumstances, they were essentially working as a team, so for the family it was two against one, and the family had the finite resources available to them on legal aid and only as an exceptional grant of case funding ("ECF")"[47]

52. Too often we have seen how multiple legal teams representing state bodies at an inquest are able to split work between them, often supporting each other's legal arguments to restrict scope, limit witnesses and argue against critical questions or conclusions. We have witnessed inquests where less experienced coroners have fallen prey to these majority positions and the pressures from state lawyers.

53. There is a clear link between meaningful access to justice and the outcome of the legal process. Properly conducted inquests, in which families have been legally represented, can help ensure scrutiny and examine and address the systems and practices that are meant to ensure safety and prevent deaths. Inquests can help save lives and are a vital way of exposing unsafe systems of care or unlawful, dangerous use of force and holding public and private services to account. Funding for families therefore performs a wider public benefit.

54. In addition to the provision of legal aid, it is crucial for access to justice that families are kept informed throughout investigation processes and are signposted to sources of information that is specialised enough to advise them on the details of police-related deaths. We are deeply concerned that while time and effort has been spent by many on producing guides for bereaved families, there are persistent delays in providing necessary information to families in the period immediately following a death, which means they are uninformed about their rights to a second post mortem or where to go for specialist advice or even delays in being informed of the death. For example, the family of Jermaine Baker, who was shot by police in December 2016, watched footage of the immediate aftermath of the death on the internet, unaware of the identity of the deceased, and were not contacted for ten hours. Delay creates suspicion for many families that the police are spending time creating a 'story' before information about the death emerges.

[47] Police Action Lawyers Group, Submission to Home Affairs Select Committee Inquiry concerning Race and Policing, 6 July 2020

55. Other aspects to ensure families are involved in a meaning way throughout the post death investigation processes include family involvement in setting the Terms of Reference and being given the opportunity early on to put forward their key concerns. This may well include concerns about how racism and discrimination informed the treatment and response to their relative.

Accountability: misconduct and prosecutions

56. INQUEST has long documented the inadequacy or ineffectiveness of police conduct disciplinary processes, and the failures to bring prosecutions in police death cases: these expose the significant shortcomings of accountability processes.

Misconduct

57. There is a historic and ongoing failure of the IOPC and police to adequately act on misconduct issues arising in police related deaths. In cases where gross misconduct proceedings have been brought against police officers by the IOPC and Appropriate Authority following a death, charges are often not proven through this process, despite where there might be convincing evidence to the contrary or a critical inquest conclusion. In rare cases where misconduct has been proven it has often been appealed by the officers. These failures are particularly evident in case where the deceased was Black, as we illustrate here in relation to cases of misconduct brought over the past three years:

- **Seni Lewis:** in 2017, a police misconduct panel dismissed charges of gross misconduct against six police officers relating to the death of Seni.[48]
- **Adrian McDonald:** in 2017 misconduct charges were brought against officers involved and were proved against two officers. An appeal by the officers was upheld by a Police Appeals Tribunal in 2018 citing a 'misunderstanding' at the original three day hearing.[49]
- **Kingsley Burrell:** in 2018 gross misconduct charges were proven against one of three officers involved in the death of Kingsley Burrell for providing 'dishonest accounts' following his death. All officers were cleared of using excessive force.[50]
- **Jermaine Baker:** in 2018, the IOPC directed the Metropolitan Police to bring gross misconduct proceedings for the actions of the officer that fatally shot Jermaine in 2015. The officer brought a judicial review to challenge the direction which was successful in the high court. In 2020 the Court of Appeal overturned that decision[51] meaning that the officer should now face proceedings for gross misconduct, however he has now applied for permission to appeal to the Supreme Court to challenge this decision (see also paragraph 50).

[48] Officers cleared by Met of gross misconduct following the restraint death of Olaseni Lewis (2017) https://www.inquest.org.uk/olaseni-lewis-officers-cleared
[49] Family of Adrian McDonald devastated as officers involved in death successfully appeal proven misconduct charges (2018) https://www.inquest.org.uk/adrian-mcdonald-misconduct-appeal
[50] Gross misconduct charges proven against one West Midlands Police officer following 2011 restraint death of Kingsley Burrell (2018) https://www.inquest.org.uk/gross-misconduct-proven-burrell
[51] Court of Appeal reject police attempts to weaken accountability for use of force https://www.inquest.org.uk/coa-jermaine-baker

- **Leon Briggs:** in 2019 the IOPC withdrew directions to bring gross misconduct proceedings for five officers after Bedfordshire police force said they would not present any evidence against its officers.[52]
- **Sean Rigg:** in 2019, a police misconduct panel dismissed all charges against five Metropolitan police officers.[53] The gross misconduct allegations included failing to identify and treat Sean as a person with mental ill health, excessive restraint, and false evidence given to the IOPC and at the inquest.
- **Edson Da Costa:** in 2020 it was discovered by the family that the one officer due to face misconduct left the force in 2019 before disciplinary proceedings could begin.[54]

58. In some of these cases the misconduct decision failed to reflect damning evidence heard at the inquest or critical conclusions about the shortcomings of the police. In other cases, the police sought to avoid accountability through abuse of process arguments, judicial reviews and leaving the police force.

Prosecutions

59. Our monitoring shows that since 1990 that there have been nine unlawful killing conclusions returned by juries at inquests into deaths involving the police and one unlawful killing finding recorded by a public inquiry into a police shooting, as well as other findings critical of force used. Yet none of these have resulted in a successful murder or manslaughter prosecution. Indeed, we are not aware of a single occasion when the police have been successfully prosecuted for manslaughter at an individual or corporate level.

60. It is clear from our experience of police death cases that police conduct which is potentially criminal is not subjected to the same investigative steps as criminal offences of members of the public. One of the ongoing concerns of families in these kinds of cases is the failure to treat deaths in custody or following police contact as potential crimes and conduct important evidence-gathering at the beginning of the investigation. In relation to the death of Sean Rigg, the lawyers involved made a number of complaints to the IPCC about failings in securing crucial forensic evidence.

61. In cases involving use of force and custody safety we have seen a failure to consider corporate manslaughter charges in a range of circumstances that raise systemic senior management failings.

62. At the heart of this are our concerns that the rule of law does not apply to the police for abuses of power in the same way as it does to an ordinary citizen. The central experience of impunity and the damage it does to victims, to public confidence and trust and to the very fabric of the rule of law and democratic accountability cannot be overstated.

[52] IOPC withdraw directions to bring gross misconduct proceedings for five Bedfordshire Police officers following death of Leon Briggs (2020) https://www.inquest.org.uk/briggs-misconduct-withdrawal
[53] All charges of gross misconduct against officers involved in the death of Sean Rigg dismissed (2016) https://www.inquest.org.uk/sean-rigg-miscondcut
[54] Police officer in death case resigned before disciplinary action (Mark Townsend, 2020) https://www.theguardian.com/uk-news/2020/nov/28/police-officer-in-death-case-resigned-before-disciplinary-action

63. Police officers must be held to account for account for abuses of power. The failure to do so undermines community confidence in the police and is damaging to police and community relations. In relation to deaths of Black men following police conduct, these failures come at the end of a long process that has already been characterised by discrimination, disbelief, indifference, stereotyping and caused mistrust and scepticism. The lack of trust and confidence in the police complaints systems will not be easy to overcome for those bereaved families who, in the words of Dame Elish Angiolini in relation to two of these cases, have experienced an "*appalling level of delays, obfuscations and institutional blunders.*"

Accountability: prevention and change

64. Every family INQUEST has worked with has identified the overriding need to establish the truth about how their loved one died, to hold those responsible to account and to bring about changes to prevent further deaths occurring. We are concerned that there is a wholesale inadequacy in the accountability framework to ensure prevention and change. As we have indicated above, we have seen the same issues - the unacceptable practices and failures that have led to deaths of Black people in contact with the police, and the inadequacies in investigation and bringing these cases to justice – repeated far too many times over. There is an urgent need to strengthen the emphasis in accountability on prevention and change, and we would encourage the OHCHR to explore this further as it is underdeveloped also in international human rights law.

65. Successive governments, parliaments and other state bodies have established reviews and inquiries, drafted reports and made countless recommendations. Politicians and senior officials respond with hollow promises that "lessons have been learnt". Coroners issue important 'prevention of future death' reports, and inspection and monitoring bodies perform their role within a framework of preventing ill treatment in detention. Yet bereaved families have shared with INQUEST that they feel deep frustration that their experiences regrettably echoed those of families newly bereaved despite the years between them. There are few stronger examples of this than in the cases of Sean Rigg, Seni Lewis and Kevin Clarke.

66. INQUEST remains concerned that whilst shocking and contentious cases or critical reports may generate an immediate response and commitment to change and learning, that learning is not sustained, does not become embedded in approach and practice, with the risk that the same cycles and patterns repeat. We have observed a lack of political will from the government to implement recommendations specifically seeking to address anti-Black racism and discrimination in policing, health, immigration and criminal justice systems.

67. For families of people who have died who were Black, an important aspect of getting to the truth is an examination of whether race or racism and discriminatory attitudes and assumptions informed the treatment of the person who died. This should be central to the terms of reference of any independent investigation or review following a death of someone in state care or custody.

68. It is INQUEST's view that a guiding principle for accountability processes must be to prevent future deaths. But this must move beyond a cyclical process of reviews and

reports, to ensuring tangible and long-lasting change. There must be greater scrutiny of and accountability for the implementation of recommendations from all of these processes. As the family member of a Black man who died in prison told us: *"You'll lose the accountability if they simply know that all they have to do is put in a report to say that those recommendations have been completed."*

69. It is for these reasons that INQUEST has proposed the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning and implementation arising out of state-related deaths. This is the only way to secure proper cross-sector learning and public transparency. In relation to the deaths of Black people in state care or custody, this mechanism should allow state bodies and those that hold them to account to develop a cross-sector picture of reoccurring issues. Any new framework should also be accountable to Parliament to enable the advantage of parliamentary oversight and debate, with consideration to report annually to Parliamentary Select Committees.[55]

70. Finally, there is an urgent need for politicians and lawmakers to look beyond the system we have: it is time to face up to the need for structural change to a system that allows people with mental ill health or addictions to die at the hands of the police or in police custody instead of investing in community services for people to access.

Conclusion and recommendations

71. Our concern is that even in a country that makes claims to have a sophisticated and well-embedded institutional framework for accountability, these institutions fail in the very basic function of holding police officers to account for wrongdoing or criminality. The powerful interests of state agents are able to undermine accountability and the state fails to provide reparation in cases of human rights violations. It is INQUEST's experience that there is an ever present need to challenge this accountability framework, and that this is too often left to the very bereaved families who have been failed by them. Without the continued scrutiny and challenge – by lawyers, activists, parliamentarians, and organisations such as INQUEST – these accountability bodies can too often become self-serving or dysfunctional bureaucracies that fail in their most basic functions.

72. There is a risk that questions of accountability lead to answers focussed on bureaucratic, process-based solutions that can be endlessly tweaked and refined without ever addressing the fundamental questions of truth and justice, or challenge deeply rooted systems of racial prejudice and racism. In the context of law enforcement, it must be noted that the very bodies whose very legitimacy depends upon an effective system of public accountability (the police and related stakeholders) are those who often appear fiercely resistant to it. As we evidence above, the system of accountability that is in place continues to fail bereaved families or tackle the causes or consequences of structural racism against Black people: we hope that the OHCHR report will make concrete recommendations that help address these.

[55] See INQUEST submission to the Justice Select Committee Inquiry into the Coroner Service, September 2020, paragraphs 31-35 https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e404f863-cdfb-47b6-8e34-a65118520331.

73. We make the following recommendations for your consideration:

a. Addressing race and racism

I. All detention authorities and relevant monitoring bodies must provide disaggregated data about race and ethnicity. With relation specifically to deaths in custody, there should be an agreed, coherent set of statistics published regularly which includes disaggregated information on the number and features of these deaths, including ethnicity.

II. All accountability bodies (including investigation and monitoring bodies) and investigatory processes (such as inquiries, reviews, inquests) should ensure that race and discrimination issues are an integral and proactive part of their work. This should include examination of similarities between cases and repeated issues, to build up a picture of attitudes and practices that may affect individual experiences.

III. Relevant Parliamentary committees and human rights commissions (NHRIs) should monitor and hold these bodies to account for the extent to which they fulfil these responsibilities.

IV. Given the global context of racism in law enforcement, all States should ensure there is an explicit duty to examine racism and discriminatory treatment in the legal framework and operating documents of police complaints and investigations bodies.

V. Jointly with other relevant international human rights bodies, OHCHR should develop international guidance to inform investigation and monitoring bodies of their specific practical responsibilities to provide accountability, remedy and redress and address impunity in relation to racism, law enforcement and deaths, in line with international human rights standards and best practice. For the purposes of NPMs this should include specific guidance on applying their preventive mandate to deeply rooted and longstanding issues of disproportionality.

b. Timeliness and delays

I. To prevent delays, clear protocols and timelines should be in place to ensure that different agencies (eg. police investigations bodies, prosecutors) involved in bringing cases to justice work together from the outset and throughout a case.

II. Timeframes for the completion of investigations and the consideration of misconduct and prosecution should be clearly laid out at the beginning of every case. Accounts from officers and witnesses must be obtained as early as possible and investigations by different bodies should proceed without delay and in parallel.

c. Conduct of the state

I. Independent investigations bodies should state clearly in their reports when police officers have not cooperated with their investigations.

II. In relation to deaths in custody and following police contact, there should be a provision in law that puts the burden of proof on police officers to justify their actions where they have refused to answer questions.

III. There should be clear and strict guidance on the treatment of family witnesses through investigation and accountability processes, to prevent aggressive and inappropriate lines of questioning. This guidance should set out steps to prevent re-traumatising bereaved witnesses. The guidance should include clear protocols for escalating concerns where any tactics to smear or discredit witnesses or the deceased are used to the relevant senior official or judge.

d. Access to justice and meaningful participation

I. There should be automatic non means tested legal aid funding to families for specialist legal representation immediately following a state related death to cover preparation and representation at the inquest and other legal processes.

II. Bereaved families should be signposted to sources of specialised information to advise them of sources of support and the process of investigating a death in custody.

III. Funding should allow equivalent representation to that enjoyed by state bodies/public authorities and corporate bodies represented.

IV. Bereaved families should be kept informed regularly and proactively throughout investigation processes, preferably by a designated liaison person.

e. Accountability: misconduct and prosecutions

I. Independent investigations into police deaths need a rigorous and consistent threshold for considering potential disciplinary action or criminal prosecution, with staff training to ensure this is understood. The potential for any police death to lead to misconduct or criminal proceedings should inform all actions taken from the earliest stage in investigations.

f. ***Accountability: prevention and change***

I. Any independent investigation or review following a death of someone in state care or custody where there is a possibility that race, racism or discriminatory attitudes played a role should include a specific focus on these in their terms of reference.

II. Establish an independent state-level mechanism (a 'National Oversight Mechanism'), accountable to Parliament, tasked with the duty to collate, analyse and monitor learning and implementation arising out of police deaths, with a specific duty to consider patterns and trends relating to race and ethnicity. It

should ensure the consultation and input of bereaved families and community groups in its work.

III. United Nations human rights treaty bodies, special procedures and the Human Rights Council should ensure greater scrutiny of the steps taken by States to prevent racism in the context of law enforcement, and hold them to account for any failure to ensure tangible change.

INQUEST, December 2020

3rd Floor 89-93 Fonthill Road • London • N4 3JH • Telephone: 020 7263 1111 • Fax: 020 7561 0799 • Website: inquest.org.uk