INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST submission to the Joint Committee on Human Rights inquiry into Black people, racism and human rights

September 2020

Background

1. INQUEST is the only charity providing expertise on state related deaths and their investigation.[1] We welcome this inquiry which resonates with our longstanding work on deaths of Black people in custody and detention and other deaths raising concerns about racism and human rights abuses. This is an important human rights issue that concerns racism and discrimination with repercussions to the right to life and the duty of the state to protect life.[2]

2. Whilst this submission focuses on our work alongside families following deaths in custody and detention, institutional racism and systemic neglect is endemic across society. Whether it is the racial and health inequalities that has seen the devastation of deaths from COVID-19 disproportionately impacting Black and Asian communities, or the preventable and forewarned fire at Grenfell Tower that demonstrates where profit was pursued over safety – both point to the important intersectionality of race and class which underpins many deaths engaging issues of state and corporate accountability[3].

3. INQUEST's evidence draws from our involvement, alongside bereaved families, in many reports and reviews that address directly or indirectly issues of racism, in areas of detention and health specified by the Committee's terms of reference. Importantly, some have recognised structural and institutional racism (often informed by those with lived experience or by the families of those who have died).[4]

4. Many of the cases INQUEST has worked on have presented a disturbing picture of violence, racism and inhumane attitudes towards people in distress; ascribing stereotypical characteristics of extraordinary strength, dangerousness and criminality to Black people. The racial stereotype of 'big, black and dangerous,' 'violent' and 'volatile', when woven into the culture and practice of the police and other detention settings, can lead to the disproportionate and sometimes fatal use of force and neglect.[5]

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[1] INQUEST provides expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody and is a member of the Independent Advisory Panel on Deaths in Custody.

[2] We focus particularly on Article 2 (the right to life), Article 3 (the prohibition of torture and inhuman and degrading treatment) and subsequently Article 14 (the protection of all rights without discrimination)

[3] This is elaborated further in Deborah Coles' chapter in Justice Matters https://www.lag.org.uk/?id=208817

[4] These include the Stephen Lawrence Inquiry (1997), the Independent Inquiry into the death of David Bennett (2003), Zahid Mubarek Inquiry (2006), Casale Review (2013), The Angiolini Review (2017) and the Independent Review of the Mental Health Act (2018); The Harris Review (2015).

[5] See, among others, INQUEST's submission 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

5. In this submission we draw specifically from our experience during and after the *Angiolini Review into Deaths and Serious Incidents in Police Custody* (2017). This review is of particular relevance as it was set up as a direct response to the deaths of Sean Rigg and Olaseni Lewis, two Black men who died after the use of restraint and the *"appalling level of delays, obfuscations and institutional blunders that followed"*.[6] Unusually for a review that is not explicitly focussed on race, the report considers disproportionality, racial stereotyping and accountability in detail.

Racial inequalities and racism: the experience of bereaved Black families

6. The focus of this inquiry on *why* progress has not been made is welcome. However, to identify why this is the case, we think there still needs to be greater understanding and recognition of the deeply rooted racial inequalities and racism that exists. In Annexe 1 we set out some of the key data that illustrates a continuum of racial inequalities that are aggravated in state custody and detention, and lead to racialised state harm and violence.

7. In preparation for this submission, we sought insight from the family members of Black people who had died in police custody, prison or mental health settings, who INQUEST have supported through the investigation and inquest processes.[7]

8. Families spoke of feeling as though they were having to censor themselves or not reference race when the deaths of their loved ones were being investigated, despite knowing it was a factor, because it might reflect badly on them. They also raised not wanting to have to challenge racist perceptions whilst also navigating the complexity of the process.

"I didn't want the perception of the public, oh they've got a chip on their shoulder because he's Black…I knew it was there just didn't highlight it. It was also not highlighted by the IPPC" - Marcia Rigg, sister of Sean Rigg

"With my nephew I haven't made reference to race at all and I've deliberately done that as well. Everything I have put in writing I've just challenged the facts as they see and asked for proof for everything they've said that they believe is fact" - Anonymous family member

"When it comes to racism… they expected her to be as a Black woman mad and angry and loud and aggressive, where my niece was very soft, very gentle" - Anonymous family member

"We didn't mention anything about racism either because it was more of a family discussion that we spoke about racism. When we got together to talk about what was happening with us we thought, what else could it be? They're so hostile towards you" - Marilyn Medford-Hawkins, sister of Junior Medford

[6] Dame Elish Angiolini QC (30 October 2017), *Deaths and serious incidents in police custody*, paragraph 1.8, available: https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody INQUEST's Deborah Coles was expert advisor to the review.
[7] INQUEST held an online *Family Consultation Café* on the 2 September 2020 with eight family members whose relatives had died between 2008 and 2019 across different state settings including police custody, prison, and in mental health detention.

9. Families also raised their experience of racist narratives being introduced during post death processes. These include attempts to demonise the person who has died and build up a negative reputation, which creates the idea of an "undeserving" victim, deflects attention away from official incompetence or wrongdoing with misinformation. Families also told us they felt that instead of the death of their loved one being investigated, it was their private life and that of their relative that was subject to the most scrutiny.

"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

"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

"We were stone-walled; we were treated like criminals. [The IOPC] were just not forthcoming. They had no compassion" - Marilyn Medford-Hawkins

"The [IPCC] were investigating the family, instead of the officers" Marcia Rigg

Accountability and transparency

"We know that things are not changing over the years but it's clear to me that the reason why it's not changing and why recommendations are never being put forward is because there's no one challenging, we're [families] challenging but no one from the political side the reports are actually the same, the only changes are the person that has actually died" - Anonymous bereaved family

10. It is a common phenomenon for reports to be left to gather dust and their recommendations remain unimplemented. For bereaved families, like those who invested time, emotion and energy into the Angiolini review, the failure to make progress is a betrayal.

"*What's happened to all the other reports which we all participated in?"* - Anonymous bereaved family member

"When are they are going to listen to us?" - Anonymous bereaved family member

"I'd love to know what the government will do because…we're bending over backwards, we're doing research, we're doing talks, we're doing all sorts of stuff but yet there is no accountability. When are they are going to listen to us, when are they going to listen to us as a family." - Anonymous family member

11. All of the families we spoke to as part of our consultation reported feeling disillusioned by the cyclical nature of reviews, reports and recommendations and the frustration that their experiences regrettably echoed those of families newly bereaved despite the years between them. The continued failure in progress on racism and disproportionality is a failure in the state's human rights obligations to *act* to prevent future deaths.

"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" - Anonymous family member

12. Too often, there is little or no transparency or accountability for how recommendations are being acted upon. The process by which responses to recommendations are published is opaque and there is too little publicity or scrutiny of the responses which are crucial documents.

13. We have noted two particularly concerning practices: (a) cherry picking of 'easy' recommendations to allow a positive response, while recommendations requiring tackling structural racism are ignored (e.g. Angiolini); (b) Action plans accepting recommendations and setting out steps that will be taken to address them that are then not implemented.[8]

14. Where recommendations arise from a death in custody, such as in an investigations or inquests, it should be a given that the authorities responsible report back to families for the action taken in response. Yet this is rarely the case.[9]

From the individual to the systemic

15. 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.

16. The absence of a framework or coordinated response among public bodies to ensure inquiry or inquest outcomes feed into concrete implementation of learning and demonstrable action is a significant failure of accountability that must be addressed. Narrative findings from inquests, which often provide a detailed account of systemic failings, are not published or collated.

17. One example where the wider relevance of the failures in a particular case has been recognised as a systemic issue is the adoption of the Mental Health (Use of Force) Act ("Seni's Law"), following from the death of Olaseni Lewis as a result of prolonged restraint by police officers whilst a voluntary mental health patient. A crucial law aimed at addressing the disproportionate use of restraint against Black people in mental health detention, which requires healthcare providers to keep records of use of force and training in de-escalation techniques. Despite the Bill receiving royal assent in 2018, the government have neither set a commencement date nor issued guidance on it. As this committee knows, the excessive use of restraint is a real and enduring issue during lockdown which makes these delays even more unjustifiable.

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[8] An unannounced inspection of HMYOI Feltham A in January 2019 recommended that "Consultation arrangements for children with protected characteristics should be formalised and consistent so that children can express their distinctive views and their specific concerns can be addressed." (https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/06/Feltham-A-CYP-Web-2019.pdf para 2.50). The Action Plan said it had been completed https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/06/Action-Plan-Feltham-A-FINAL-DRAFT-Agreed.pdf (para 5.28) but at the following announced inspection six months later, HMIP said no progress had been made and the recommendation was repeated https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/10/Feltham-A-Web-2019.pdf (para 2.48).

[9] https://www.judiciary.uk/wp-content/uploads/2020/08/guidance-no-5-reports-to-prevent-future-deaths.pdf para 47.

Political will

"We have to raise the ugly head because it's not a fashionable discussion by the government. The government know they just choose not to implement the recommendations and not make them accountable" - Marcia Rigg

18. INQUEST has 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.

19. A key example is the government's response to the Angiolini review in 2017 and progress report in 2019, which make virtually no reference to racism, ethnicity,[10] disproportionality or discrimination, despite the Angiolini review having put forward nine recommendations specifically referencing institutional racism, race or discrimination.[11] Our monitoring shows that since the Angiolini review was published in November 2017, there have been a further six deaths of Black men in police contact, three of which featured restraint.

20. 21 months since the Independent Review of the Mental Health Act 1983, was published in December 2018, the government are yet to provide a response. [12] This means that the government's intention to meet the recommendations, which set out to "represent a shift in tackling racial inequalities by accepting that the structure of existing systems needs to change gradually to improve overall quality of services"[13] remain unanswered. This is all the more concerning when we consider the finding of the Inquiry into the death of David 'Rocky' Bennett of institutional racism in mental health services back in 2013. Then as now Black people are more likely to be restrained in mental health settings.

21. We urge the Committee, through the scope of this inquiry, to consider ways in which Parliament can hold governments to account for such failures, which should be seen not merely as the failure to 'implement a report', but the failure in many instances to acknowledge and act upon longstanding social and economic inequalities experienced by Black people in the UK.

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[10] Home Office (2017) Deaths and serious incidents in police custody: government response https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody-government-response. In the government's response to the review in 2017 ethnicity is only referenced in relation to data being collected and published in relation to police use of force. See also Department of Health and Social Care, Home Office and Ministry of Justice (2018) Deaths in police custody: progress update https://www.gov.uk/government/publications/deaths-in-police-custody-progress-update

[11] Including that IPCC investigators should consider if discriminatory attitudes have played a part in restraint related death, that national policing bodies and police forces should implement mandatory and refresher training on the nature of race issues to confront discriminatory assumptions and stereotypes and that police training should include an understanding of institutional racism.

[12] The government responded to a parliamentary question in January 2020 (https://questions-statements.parliament.uk/written-questions/detail/2020-01-15/3763) saying they will be publishing a White Paper which will set out the Government's response to Sir Simon Wessely's Independent Review of the Mental Health Act. This is awaited.

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf p163

Ensuring racism is in scope

22. Although the committee's focus on the lack of progress in implementing recommendations is welcome, we believe there is a wider problem where racism is simply not in scope, or properly examined, by reviews, inquiries and oversight bodies. Few reports that do not have a specific focus on race tackle underlying race or racism issues head on. 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, despite ample evidence about the disproportionality of Black men dying after restraint.[14]

23. Central to the terms of reference of any independent investigation or review following a death of someone in state care or custody, should be an examination and challenge of whether race or racism and discriminatory attitudes and assumptions informed the treatment of the person who died.

Data

24. There is an urgent need to strengthen the consistency of data across all detention and custody settings, and for this to include disaggregated data about race and ethnicity. In particular there is a longstanding failure to provide detailed information about deaths of people in the care of the state in mental health and learning disability settings[15]. Without this data, it is impossible for policy-makers and detaining authorities to understand and act on the issues before them, and for other stakeholders – including Parliament, NGOs, academics, activists – to hold them to account for making progress. In relation to deaths specifically, INQUEST recommends the introduction of an agreed, coherent set of published statistics which includes disaggregated information necessary to provide an overview of the number and features of these deaths, including ethnicity.[16]

Who else plays a role in making progress?

25. We urge the Committee to consider the broad range of actors who should all play a part in ensuring progress on tackling racism in detention, and the ways in which they could and should do this.

[14] 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

[15] Data on the deaths of Black people in mental health setting is not publically available as the CQC does not disaggregate the ethnicities within 'Black and Minority Ethnic' https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf

[16] As recommended in our 2015 report Deaths in Mental Health Detention: An investigation framework fit for purpose? https://www.inquest.org.uk/deaths-in-mental-health-detention

26. Although rarely with any formal responsibility in implementing recommendations from reviews and inquiries, oversight bodies such as ombudsmen, regulators and inspectorates play a crucial role. Their role should include interrogating data they produce – from inspections, complaints, investigations – where this points to concerns about racial inequalities, and learning directly from reviews and inquiries into these issues.

27. It is, for example, disappointing that the annual reports of HMIP consistently identify that prisoners from a Black or minority ethnic background report a more negative experience in most areas of prison life than white prisoners, yet do not appear to have done any thematic work to look at this in more detail.[17] Similarly, we note that while CQC's Mental Health Act annual report does acknowledge the disproportionate detention of Black and minority ethnic groups[18], it provides little exploration of the reasons for this, which is an inadequate response to an issue of this scale. It would be desirable for oversight bodies to respond publicly with how they intend to take on the findings and recommendations from reviews such as Angiolini and Lammy, which are entirely relevant to their own work. There is a role for Parliament and this committee in particular in challenging all oversight and human rights bodies for their efforts to support progress, but we consider that efforts to date have been patchy.

Conclusions and recommendations

28. The systems for identifying and sustaining change are not fit for purpose and do not adequately meet the needs and hopes of bereaved families, or satisfy wider public need. As demonstrated in the above experiences of families, there is a lack of rigour and accountability of state institutions, inquest and investigation bodies in addressing issues of racism. This undermines trust and public confidence in the justice system, the rule of law and democratic accountability.

29. We are concerned that the new Commission on Race and Ethnic Disparities' focus on reviewing "progress on taking forward previous Government action on ethnic disparities, including the implementation of past reviews" merely prolongs any real action to implement these reviews. When seen against the Commission's terms of reference and previously-expressed views of some of its members, we are concerned that there is a real risk of rowing back.

30. One concrete step that INQUEST has long advocated is the publication of all inquest jury and coroner's reports in a searchable format, including the ability to search according to ethnicity. This would enable all those engaged in thinking about, and legislating for social, health and criminal justice policy to track the progress, or lack of progress, in addressing structural racism.

[17] See HMIP annual report 2018-19 p29 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/07/6.5563_HMI-Prisons-AR_2018-19_WEB_FINAL_040719.pdf
[18] Care and Quality Commission (2019) Monitoring the mental health act in 2018/2019 https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf

31. INQUEST believes that there is an overwhelming case for 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. [19] Such a mechanism should allow state bodies and those that hold them to account to develop a cross-sector picture of reoccurring issues impacting the deaths of Black people in state care and custody. 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.

32. Finally, we hope that the renewed focus on structural racism that has come out of the Black Lives Matter protests, and in response to the death of George Floyd, means these issues are no longer side-lined. It is high time that challenging racial inequalities and racism took centre stage in the political and policy agenda.

INQUEST, September 2020

Annex 1: Racial inequalities, racism and detention

1. To understand the issues that the Committee are considering, it is necessary to focus on the broader social, economic and political context of policing, imprisonment, immigration, health and legal systems in maintaining and exacerbating racial inequalities.

    - In 2018/2019 Black people were 9.5 times more likely than White people to be stopped and searched by police in England and Wales.[20]
    - 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.[21]
    - As of June 2020 7.7% of the prison population[22] were Black despite the comprising 3.4% of the population in England and Wales.[23]
    - The use of remand to prison is more pronounced for Black women than white women. In magistrates courts in 2019, 59 per cent of white women remanded in custody did not go on to receive an immediate prison sentence, compared with 73 per cent of Black women.[24]

[19] This recommendation has been previously endorsed by the Joint Committee on Human Rights in the interim report on Mental Health and Deaths in Prison (2017) https://publications.parliament.uk/pa/jt201617/jtselect/jtrights/893/893.pdf
[20] Ministry of Justice (2020) Stop and Search https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/policing/stop-and-search/latest#by-ethnicity
[21] Care and Quality Commission (CQC) (2019) Monitoring the mental health act https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf
[22] Ministry of Justice (2020) Prison Population: 20 June https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2020--2
[23] 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
[24] https://www.gov.uk/government/statistics/criminal-justice-system-statistics-quarterly-december-2019

2. Such racial inequalities are further aggravated in state custody and detention:

    - In 2018/2019 Black people were more than five times as likely to have force used against them by police as White people and were subject to the use of Tasers at almost eight times the rate of White people.[25]
    - 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.[26]
    - 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.[27]
    - 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 males across the estate, especially younger Black males.[28]
    - 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.[29]

3. Our casework and monitoring shows that at the sharp end of this continuum of racialised state harm and violence is the disproportionate number of Black people who die after the use of lethal force and neglect by the State. These deaths connect with the Black community's experience of structural racism, over-policing and criminalisation. In respect of Black women who have died in prison and mental health settings as a result of neglect, we have also reported concerns about the role racism plays in their treatment, with their calls for healthcare being disbelieved or their disturbed behaviour being treated as a discipline and control problem.[30]

4. We set out below a sample of cases that illustrate the points raised above which we hope will be considered by the Committee:

[25] Home Office (2019) Police use of force statistics, England and Wales: April 2018 to March 2019 https://www.gov.uk/government/statistics/police-use-of-force-statistics-england-and-wales-april-2018-to-march-2019
[26] 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
[27] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report
[28] 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)*
[29] INQUEST casework and monitoring 2020
[30] 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

Christopher Alder MEDIA RELEASE
Christopher Alder, 37 died following arrest and restraint by police in 1998. In 2000 the jury at the inquest returned a conclusion of unlawful killing after hearing evidence that he was left unconscious, face down on the floor of the police station, partially dressed and clearly injured. In 2012 the family discovered that the person they thought they buried at Christopher's funeral twelve years prior was in fact the body of a 77 year old woman, after his body was found in a police mortuary. The family continue to pursue legal action on this. In 2013 it was revealed that Christopher's family and their lawyer were subject to extensive police surveillance during the inquest into his death, including attempts to listen to conversations that were likely to include matters which were private, confidential and subject to legal professional privilege.

Rocky Bennett BRIEFING
Rocky Bennett, 38 died following the use of restraint by five nurses whilst a detained mental health patient in 1998. Rocky had been a patient at the Norvic Clinic in Norwich for three years. At the inquest in 2001 the jury concluded Rocky's death had been an accidental death aggravated by neglect, and said that the cause of death was due to prolonged restraint and long-term antipsychotic drug therapy. His death prompted a public inquiry 'The Independent Inquiry into the death of David Bennett' (2003) which found institutional racism within the mental health service.

Kingsley Burrell MEDIA RELEASE
Kingsley Burrell, 29 died in 2011 following a prolonged restraint by police whilst he was a detained patient under the Mental Health Act. Kingsley was forcibly restrained by means of rear cuffs, leg straps multiple times in the space of four days. When the medical staff observed that his respiration had dropped to a worrying rate, no one entered the room. When they finally did, they found that Kingsley had suffered a cardiac arrest. Further delays followed in locating a functioning defibrillator and in calling an ambulance. In 2015, the inquest concluded neglect and unreasonable police force contributed to his death, amidst a raft of other highly critical findings including that police officers lied about the circumstances in which Kingsley was left in seclusion.

Leon Briggs MEDIA RELEASE
Leon Briggs, 39 was detained under the Mental Health Act and restrained on the street by police officers in November 2013. After being transported to Luton Police Station Leon was placed in a cell where he was further restrained. Leon became unresponsive and an ambulance was called, he was later pronounced dead at the hospital. In 2020 the IOPC withdrew directions to bring gross misconduct proceedings against the five Bedfordshire Police officers involved. An inquest is awaited.

Dexter Bristol MEDIA RELEASE
Dexter Bristol, 58, died after collapsing on the street in London in 2018. In the year and a half before his death, Dexter's family say he was placed under unbearable stress by the Home Office as he was required to prove his settled status, despite residing in the UK for 50 years. In late 2016 he was told he was unable to start the job he had been offered, because he did not have an official Right to Work document to prove his settled status in the UK. Dexter was prohibited from obtaining work, and feared losing his benefits, council housing, and access to secondary medical care and being deported. After the initial inquest was quashed, the second inquest concluded he died from heart failure and was under intense stress from a series of problems at the time of his death.

Natasha Chin MEDIA RELEASE
Natasha Chin, 39, died in 2016, 36 hours after entering Sodexo run HMP Bronzefield. Despite being on a specialist wing for people with drug and alcohol dependencies, on the day she died she had been vomiting for at least nine hours and did not collect essential medication. Healthcare staff did not follow this up or properly respond to prison officers' requests to attend her cell. The inquest jury concluded neglect and systemic failures by prison and healthcare providers contributed to her death.

Darren Cumberbatch MEDIA RELEASE
Darren Cumberbatch, 32 died following restraint and use of force by the police whilst he was experiencing a mental health crisis in 2017. Darren was restrained by seven officers, during which he experienced baton strikes, other physical strikes, multiple punches, stamping, PAVA spray and Tasers were discharged three times, all inside a small toilet cubical. Once arrested, he was then restrained in the prone position (chest down) outside the toilet area and was further restrained as he was taken to a police van. After this restraint officers recognised Darren's need for emergency treatment. Despite being very ill by the time of his arrival at A&E he remained in mechanical restraints at the hospital for over an hour and was restrained intermittently at the hospital after that.

Rashan Charles MEDIA RELEASE
Rashan Charles, 20, died following restraint by police officers in Hackney 2017. Despite no knowledge of or intelligence on Rashan, an officer pursued him after he exited a vehicle which had been 'acting strangely'. Footage shows the officer following Rashan into the shop, immediately restraining then taking him to the floor. A bystander became involved in the restraint. At one point Rashan grasps toward his face, then his arm is taken back and handcuffed. The officer then turned Rashan on his side, and begins to tell him to "spit it out", believing he had hidden something in his mouth. At some point he started choking then stopped breathing. The jury concluded Rashan's death was 'accidental' but found the officer did not follow prescribed police protocol for when someone is not breathing and suspected of swallowing drugs. At the conclusion of the inquest, the family said "*The police projected a criminal caricature of Rashan even after his death.*"

Edson da Costa MEDIA RELEASE
Edson Da Costa, 25 died following contact with police in 2017. During a 'stop and search' Edson placed packages into his mouth, he was then restrained faced down by four police officers, hit with two 'distraction blows' and subject to two applications of the 'mandibular angle' pressure point pain compliance technique. CS spray was used at close proximity, despite police guidance suggesting a one metre distance. During this restraint Edson became unresponsive. He was taken to Newham Hospital where he died several days later. INQUEST reported that a hostile environment was created at the inquest through the defensive and combative tactics of police lawyers, who sought to narrow lines of inquiry and divert attention away from the circumstances that resulted in Edson's death. The jury made a majority ruling that Edson's death was 'misadventure'.

Mark Duggan MEDIA COVERAGE
Mark Duggan, 29 was killed by a firearms officer in 2011 during a police surveillance operation. The inquest into Mark's death, which followed a criminal trial, concluded he was lawfully killed despite finding that he was unarmed at the time. The IPCC and the Metropolitan Police Service each issued an apology for the way it dealt with Mark's family in the aftermath of the shooting. Recent independent forensic investigations have cast doubt into official accounts of the shooting, particularly the IPCC finding that Mark was holding or throwing away a gun.

Prince Fosu MEDIA RELEASE
Prince Fosu, 31, died at Harmondsworth Immigration Removal Centre in October 2012. The inquest in 2020 concluded finding neglect contributed to his death, with serious failures by the Home Office and across all the agencies in immigration detention, as well as failures by police who sent him there. The medical cause was sudden death following hypothermia, dehydration and malnourishment in a man with psychotic illness. Over the six days in detention, purported checks showed no positive evidence that Prince had eaten, drunk or slept and that he was naked. His bedding had been removed on the first day, and there was nothing else in his room save for it being smeared with his own faeces, urine and food debris. Despite his condition, Prince was not referred for a mental health assessment and his capacity to control his behaviour was not even considered. In 2017 the CPS announced that criminal charges would be brought against the Harmondsworth providers at the time, GEO and Primecare, under the Health and Safety at Work Act, but this decision was reversed in 2018.

Tyrone Givans MEDIA RELEASE
Tyrone Givans, 32 died at HMP Pentonville in 2018. He was profoundly deaf and had been at the prison for under three weeks, for the most part without access to hearing aids. He had a history of alcohol dependency, depression and recent self-harm. No reasonable adjustments were made to accommodate his disability and an ACCT was not opened. Tyrone asked to move wings and reported feeling unsafe. His mattress had been slashed and he was unable to sleep as he couldn't hear if people were approaching. The jury found multiple critical failings contributed to his self-inflicted death.

Annabella Landsberg MEDIA RELEASE
Annabella Landsberg, 45, died in 2017, following severe dehydration and organ failure relating to Type 2 diabetes. Annabella was critically unwell, lying unresponsive on the floor of her cell at HMP Peterborough for 21 hours with prison and healthcare staff failing to recognise her condition. A nurse was called to assess Annabella but instead of conducting any physical observation, threw a cup of water over Annabella believing her to be faking illness. The inquest jury highlighted a catalogue of serious failures in the management and healthcare systems at the Sodexo run prison.

Olaseni Lewis MEDIA RELEASE
Olaseni (Seni) Lewis, 23 died following prolonged restraint by Metropolitan Police officers at Bethlem Royal Hospital in 2010. In 2017 an inquest jury unanimously condemned the actions of police and healthcare staff who watched on as Seni was restrained by 11 police officers. The inquest found the force used was excessive, disproportionate, and contributed to Seni's death.

Police officers involved in the restraint of Seni told the inquest: *"The sound and tone didn't suggest he had difficulty in breathing, more something on the inside of him, an aggression and a ferociousness that couldn't be controlled." "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."*

Gross misconduct charges against six officers were dismissed, and no officer was charged. The family and supporters campaigned for 'Seni's Law', the Mental Health Units (Use of Force) Act, which received Royal Assent in 2018, and intends to protect patients in mental health settings from harmful use of force in future (though commencement and guidance is awaited).

Jimmy Mubenga MEDIA RELEASE
Jimmy Mubenga, 46 died following face-forward restraint in 2010 by three G4S security guards on a British Airways flight from Heathrow airport to Angola. In 2013 a jury concluded that Jimmy was unlawfully killed and that the security guards had used "unreasonable force" against him. Further, during the inquest it was revealed that despite repeatedly asking for help whilst being restrained Jimmy was given none, he died in his seat at approximately 20.24pm before the paramedics boarded the aircraft at 20.38pm. Extreme racist texts were found on two of the guards' phones forwarded to friends and colleagues. The coroner concluded in a Prevention of Future Deaths report that there was an 'unhealthy culture' in the G4S workforce and 'endemic racism'. In 2014, following a six week trail in which three G4S guards were charged with manslaughter, all were cleared.

Mikey Powell MEDIA RELEASE
Mikey Powell, 38 died during a violent restraint by West Midlands police officers in 2003. Mikey was experiencing a severe psychotic episode when police officers were called. On arrival officers drove a police car at Mikey knocking him down, then beat him with batons and used CS spray. Despite being injured Mikey was driven to a police station instead of a hospital, during this journey he was restrained face down on the floor of the police van. He died of positional asphyxia.

Sarah Reed MEDIA RELEASE
Sarah Reed, 32, died in 2016 at HMP Holloway. She had been held on remand for over three months, solely for the purpose of obtaining two psychiatric reports to confirm whether she was fit to plead, for an alleged offence which took place whilst she was a sectioned inpatient at a mental health unit. The inquest concluded that her death was self-inflicted, and that unacceptable delays in psychiatric assessment and failures in care contributed. Sarah had been previously assaulted by a police officer in 2012, an experience which aggravated her mental ill health.

Sean Rigg MEDIA RELEASE

Sean Rigg, 40 died of a cardiac arrest following restraint by Metropolitan police officers in 2008 when he was experiencing a mental health crisis. In 2012 the inquest uncovered a litany of failures by mental health services and the Metropolitan police. The jury found that the restraint lasted approximately eight minutes, and that Sean was in the prone position 'throughout the entire restraint'. They also found that the police 'failed to identify that Sean was a vulnerable person at point of arrest' and he was therefore taken to the police station instead of an A&E department or Section 136 suite, 'despite information about him being readily available and accessible'. Whilst Sean was in custody 'the police failed to uphold his basic rights and omitted to deliver the appropriate care'. In the ten years which followed Sean's death, multiple investigations and legal proceedings took place, including an independent external review of the IPCC investigation into Sean's death (the Casale review) which was highly critical of the original investigation, a criminal trail into perjury by officers involved, and gross misconduct charges directed by the IOPC which were ultimately dismissed. To date no officer has been held to account and the family continue to campaign for justice.

Azelle Rodney MEDIA RELEASE

Azelle Rodney was shot dead while seated in the back seat of a car during a police stop in 2005. Azelle was shot eight times by an officer from no more than two metres away. The officer said he believed Azelle was reaching for, and preparing to fire, a machine gun. The public inquiry, held seven years after his death, concluded that he was unlawfully killed.