Report of the independent external review of the IPCC investigation into the death of Sean Rigg

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quis custodiet ipsos custodes?

Juvenal, *Satires (first century A.D.)*

The State grants wide ranging powers to the police, including the use of force and deprivation of liberty. The Independent Police Complaints Commission (IPCC) was set up to ensure that the police render an account of their use of those powers and do not misuse them. When someone dies in custody, the public is entitled to know how and why this happened; it requires a truly independent organisation to investigate intelligently, robustly, fearlessly and effectively all the circumstances surrounding the death. The investigation must give an honest and clear-sighted account of what happened, including whether any crime or disciplinary offence occurred or any other actions or omissions not meeting the threshold of a crime or disciplinary matter but nonetheless of public concern. The IPCC has the potential to fulfil that difficult and complex role, but in the case of the death in custody of Sean Rigg in 2008 that potential was not yet fully realised. Comparing the IPCC then and now, it is clear that the IPCC is developing the ethos and skills to carry out its mandate. The Review makes a series of recommendations to encourage that process of change already underway. It is hoped that the necessary spirit will prevail at the IPCC to satisfy public confidence that the police will be held fully accountable for the exercise of the powers entrusted to them.

Executive Summary

This is the report of the independent external review (the Review) of the investigation conducted by the Independent Police Complaints Commission (IPCC)[1] into the death of Sean Rigg in police custody on 21 August 2008. The Review was carried out between November 2012 and April 2013 by Dr Silvia Casale, Martin John Corfe, who advised on matters relating to mental health and security, and James Lewis QC, who advised on legal aspects of the Review (see Appendix A). The report has been shared prior to publication with the Chairperson of the IPCC, Dame Anne Owers, senior members of the IPCC, and members of the Rigg family and their solicitors.

The Review's broad terms of reference were

- to examine the IPCC investigation in light of both the evidence given at the Coroner's Inquest and the verdict of the Inquest,
- to consider whether any further investigation is required, with a view to misconduct or criminal proceedings against any member of the police service,
- to identify any lessons to be learnt or broader issues for both the IPCC and the overall system for investigating deaths following police contact,
- to take account of the Rigg family's concerns, and
- to take account of parallel reviews relating to policing, mental health and deaths in custody.

It is easy to criticise the work of others with hindsight. **The Review recognises the complexity of IPCC investigations into deaths in custody and the difficulties inherent in the process of arriving at a true and full account.** It is not the Review's job to re-investigate the death in custody of Mr Rigg. The Review's focus is on ways to improve the system and the IPCC's work by learning from the past in order to prevent a recurrence of what tragically happened to Mr Rigg. To do that, the Review has looked again at the most important pieces of the available evidence. The Review has been greatly helped by fruitful consultations with a number of persons and organisations with knowledge in this field (see Appendix C).

Mr Rigg died on the evening of 21 August 2008 after a sustained period in police custody. He was apprehended, restrained, transferred by police van to Brixton Police Station, held in the van parked in the police station yard, then detained in the 'cage' area of the custody corridor, where he collapsed without ever having been admitted to the custody suite. During most of this time,[2] Mr Rigg was subject to means of restraint (i.e. he was cuffed with his hands behind his back); the handcuffs were removed only after he collapsed. After police officers tried CPR while waiting for an ambulance to arrive, Mr Rigg was taken by ambulance to hospital, where he was pronounced dead at 21.24 hours. Four years later, the narrative verdict of the jury at the Coroner's Inquest recorded the time of death as 20.24 hours.

The IPCC investigation triggered by his death began later that night. The IPCC is automatically notified of all deaths in custody and does not need a complaint in order to investigate. **As regards this special aspect of the IPCC's mandate, the Review considers that there is a different requirement in terms of the scope of such investigations than holds for other IPCC**

[1] A list of abbreviations used in this Review report can be found in Appendix E.
[2] From some time before 19.39 until 21.03.

investigations. When a death in custody occurs, the public has an interest not only in knowing whether any crime or misconduct has occurred, but also in understanding what has happened and why. This is especially important when there are lessons to be learnt to prevent further tragedies.

The cause of death

As is often the case, the cause of Mr Rigg's death had not been clearly ascertained by the medical experts when the IPCC carried out its investigation.

The first post-mortem, carried out by a Home Office pathologist, speculated as to the role of factors such as an underlying abnormal heart rhythm, Mr Rigg's paranoid schizophrenia and its treatment, or an underlying undetected channelopathy of the heart. It found no evidence that the death was related to the direct effects of positional asphyxia.

The second post-mortem, commissioned by the Rigg family, did not rule out cardiac arrhythmia, possibly associated with Mr Rigg's schizophrenia, psychotropic medication, and the fact that the prevailing situation of high excitement and activity required greater intake of oxygen, which might not have been available while he was under restraint. It reported no evidence of asphyxia.

The IPCC's medical expert concluded that "on the balance of probabilities circumstances surrounding the arrest and custody have to be causal to the death, although possibly in conjunction with other circumstances".[3]

At the Coroner's Inquest four years later, the narrative verdict of the jury included, under the heading "injuries and diseases causal to death", cardiac arrest, acute arrhythmia, ischaemia and partial positional asphyxia.[4] The verdict also included a majority view that the length of restraint in the prone position more than minimally contributed to Mr Rigg's death. The jury also found that an absence of appropriate care and urgency of response by the Police more than minimally contributed to Mr Rigg's death.

The challenge for the IPCC was (i) to examine all the surrounding circumstances, (ii) to consider which of these might have been causal to Mr Rigg's death, and (iii) to explore whether the conduct of, or acts of omission by, any of the people involved contributed to his death and, if so, to what extent.

[3] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 336. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

[4] Inquisition at Southwark Coroner's Court, Jury's narrative verdict, 1 August 2012. Available at http://www.gardencourtchambers.co.uk/imageUpload/File/Inquisition-for-Mr-Rigg.pdf.

Investigation and analysis

The IPCC report is, in essence, an investigation report with a detailed narrative of events, drawn primarily from the accounts given by the four police officers present during the important events: arrest, restraint, transportation, holding in the custody area of Brixton Police Station, and Mr Rigg's collapse. The narrative contains additional information from other sources, including staff at the hostel where Mr Rigg lived, members of the public who witnessed some of the events, other members of the Metropolitan Police Service (MPS), and other persons involved in what transpired during the evening.

The report also responded to formal complaints made by the Rigg family and by the manager of the hostel, by examining *inter alia* the 999 calls and the CCTV system at Brixton Police Station.

What is missing is a robust *analysis* of this information.

Police conduct

The Review has examined the series of events investigated by the IPCC, covering the period when the police were in contact with Mr Rigg. Evidence emerging at the Coroner's Inquest from oral testimony and from transcripts of interviews conducted by the IPCC raises serious questions about the conduct of some of the police officers involved in the events surrounding the death of Mr Rigg. **Based on the accumulated evidence following the inquest, the Review recommends that the IPCC reconsider the conduct of the police officers involved in the apprehension, restraint and detention of Mr Rigg, in relation to possible breaches of their duty of care, with a view to determining whether to bring misconduct proceedings.**

There are several areas of concern for the Review in relation to what the officers did and did not do. These include key issues highlighted on 22 August by the IPCC Commissioner originally overseeing the immediate response: restraint and mental health.

Restraint

The evidence indicates that Mr Rigg was kept on the ground in the prone position, with his hands cuffed behind his back, for at least eight minutes, as the Coroner's Inquest determined. During that time, the officers appear not to have moved Mr Rigg, as soon as he was under control, from prone restraint to a position on his side, sitting or standing, as would be in accordance with police standing operating procedures at the time. He was cuffed in the "rear stack" position.[5] The police took the handcuffs off Mr Rigg at around 20.14, only after he had collapsed at the police station.

[5] The stack positions (front or rear) are those where the wrists pass through the cuffs in opposite directions (rather than in the palm to palm or back to back positions). This is the standard secure position, producing the greatest degree of immobilisation. The Review understands that the rigid cuffs used were standard issue.

The IPCC investigation discovered photographic evidence of the restraint process taken on a witness's mobile telephone. Regrettably, the IPCC was not aware of the embedded timings of the photographs and therefore did not expressly request this information from their external photographic expert, who failed to present a full account that included these timings. The duration of restraint in the prone position is a serious concern in any assessment of whether the force used by police officers is necessary, proportionate and reasonable. **The Review recommends that, in light of this important evidence emerging at the inquest, the IPCC reconsider the issue of restraint, including duration of restraint in the prone position.**

The question of assault by the police

The possibility of assault on Mr Rigg by the police was addressed in the IPCC investigation. A witness alleged that one of the police officers taking him to the police van hit him several times on the head with Mr Rigg's white plimsolls and that the four officers, holding Mr Rigg like a battering ram, threw him into the van. All four police officers who attended the scene of the arrest and restraint of Mr Rigg denied the allegations. Accounts by other members of the public contradicted the allegations. Another witness called into question the reliability of the first witness; the first witness's past record of lying to the police served to discredit the allegations of assault.
After seeking advice from its legal department, the IPCC made a referral to the Crown Prosecution Service (CPS). The CPS described the police accounts provided by the IPCC as "rather inadequate and lacking in detail"[6] and indicated that the officers' statements did not "address the points raised by the witnesses."[7] The CPS advised that the police officers should not be prosecuted. This was the only referral to the CPS in the investigation of the death of Mr Rigg.

The two post-mortem examinations of Mr Rigg concluded that there was no evidence of injury indicative of assault and that the bruises and grazes observed were "not unusual in the circumstances in which he was detained."[8] **The Review considers that the absence both of physical signs of trauma attributable to assault, and of credible witness testimony to that effect, effectively ruled out a finding of assault and that the IPCC was right to conclude that it would not be fruitful to pursue criminal proceedings on that basis.**

However, following the inquest, issues related to misconduct may need to be reconsidered. Since the Coroner does not have the power to direct misconduct proceedings, it falls to the IPCC, as the only body with that power, to look again at its determination in the light of all the evidence available *since* the inquest.

Identification of Mr Rigg

The evidence of the four police officers who attended the scene of arrest was that they did not know that they were dealing with Mr Rigg. This was of crucial importance. Mr Rigg's police records

[6] CPS rationale for recommending NFA [no further action] against arresting officers, IPCC document D340.
[7] CPS rationale for recommending NFA against arresting officers, IPCC document D340.
[8] Post-mortem report and opinion provided on the request of the family's solicitors, p. 8, IPCC document D369.

would have shown markers for mental illness and violent offending. Police policy on dealing with people suffering from mental illness requires officers both to be aware of the particular risks of restraining such a person and to ensure prompt medical attention is given.

The police officers who attended the scene of arrest and restraint failed to identify Mr Rigg, despite finding his invalidated passport on him when he was searched at the scene of arrest; they discounted the passport as stolen and arrested Mr Rigg for theft of a passport (his own). Failing to identify an individual by means of his own passport is not a criminal or a misconduct offence, but **the Review considers that it indicates poor police performance at an early point in police contact with Mr Rigg. The IPCC investigation did not give sufficient emphasis to the matter of the passport.**

There was a considerable amount of information about Mr Rigg on the police system. The IPCC documented well, and in considerable detail, the information deriving from the series of 999 calls made by the forensic hostel where Mr Rigg resided. The calls began at 16.53; around 19.30, the four police officers apprehended a man (Mr Rigg) who was reported as attacking members of the public. By that time, four 999 calls had been made from the hostel and more than two and a half hours had elapsed. These calls from the hostel were linked to calls from the public only minutes before Mr Rigg's arrest.

All this information is stored electronically and can be checked by police officers operating in the field via the computer terminal in their police vehicle. The IPCC tried to ascertain whether the officers in question had checked information on the system via the computer or by radio; the IPCC interviewers did not obtain full answers. The IPCC accepted the accounts given by the four officers that they did not know who Mr Rigg was.

This had implications for identifying Mr Rigg as a person with mental health needs. The four officers did not check the name on the 'stolen' passport with police records that would have flagged Mr Rigg's mental health needs and could have alerted them to the fact that the person they were dealing with was actually Mr Rigg. He was well known to the police through repeated past contact with the police and mental health services.

In interviews with the police officers, the IPCC attempted to broach the question of identifying Mr Rigg as a person with mental health needs. The IPCC investigation report gives considerable detail about Mr Rigg's odd behaviour in public: he was walking, naked from the waist up, in public, and was reported as performing martial arts in public and trying to attack members of the public. The IPCC report also quotes the police officers' own accounts of Mr Rigg: he never spoke a word throughout his long period in police custody and, throughout the journey to Brixton Police Station, he lay on his back in the cramped footwell of the police van cage with his legs moving around the walls of the cage. The Review found this account implausible given the internal measurements of the van cage (see *Additional indications of mental health issues*).

During IPCC interviews, efforts to pose questions about recognising Mr Rigg's mental health condition were hampered by inappropriate conduct by Police Federation (PF) representatives. For example, when one of the four police officers involved in the arrest was asked whether Mr Rigg's demeanour seemed normal, the PF representative interrupted repeatedly, including asking "What's normal?" The Review considers this inappropriate and outside the PF representative's role.

The PF representative should not, as happened during this case, (i) answer questions on behalf of the officer being interviewed, (ii) ask inappropriate questions, especially those giving covert assistance to the officer being interviewed, or (iii) otherwise interfere with the process of the interview. If the officer wishes to consult with the PF representative, the interview can be stopped and a private consultation room provided. **The Review recommends that the IPCC, police and the PF agree detailed protocols about the role of the PF representative and what is acceptable conduct at IPCC interviews.**

The IPCC report stated that Mr Rigg's behaviour "would be described as strange by anybody's standards". Nonetheless, the IPCC report concluded that "The officers insist that they did not realise that Mr Rigg was suffering from a mental illness, and there is no evidence to suggest that their assertion is untrue."[9] The Review considers that there was ample evidence at the time to suggest that this assertion was improbable. The evidence emerging at the Coroner's Inquest reinforces that view. **The Review recommends further investigation of this matter.**

Custody and care at the police station

After arrival at the police station, the police continued to detain Mr Rigg in the police van for about eleven minutes, although they had sped back to the police station with their blue lights on and the custody suite was reported to be relatively quiet. Once Mr Rigg was transferred to the 'cage' area of the custody corridor, the backs of the police officers standing around him effectively blocked the view of Mr Rigg on the CCTV cameras that partially covered the 'cage'.

The IPCC investigation considered the evidence of the CCTV at Brixton Police Station, but was not able to devote the time to this exercise accorded by members of the Rigg family, who painstakingly viewed and reviewed the evidence over a period of months. **The upshot of this intensive scrutiny of the CCTV footage was the discovery by the Rigg family that the custody sergeant did not visit Mr Rigg while he was in the police van parked in the yard at Brixton Police Station.** This crucial finding emerged at the Coroner's Inquest. The IPCC had accepted Sergeant White's and PC Harratt's accounts that the sergeant had visited Mr Rigg while he was waiting in the van. The Review understands that the differing accounts provided by these police officers to the IPCC, and to the Coroner's Inquest, are the subject of a separate investigation.[10]

In light of this new evidence, the Review recommends further investigation into the care provided to Mr Rigg on his arrival at Brixton Police Station. The IPCC may wish to reconsider whether or not there was due care for Mr Rigg's safety and well-being on arrival in terms of (i) a prompt risk assessment, (ii) a prompt assessment of his medical needs (including his physical and mental health needs), and (iii) prompt provision of medical attention.

[9] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 432. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

[10] At the time of writing, the Review notes that, on 27 March 2013, IPCC investigators arrested two serving police officers and one retired police officer in connection with that investigation. Two were arrested on suspicion of perjury and perverting the course of justice and one on suspicion of perverting the course of justice; all three were bailed until May 2013.

Medical care

The FME's role in the care of Mr Rigg was confined to visiting him in the 'cage'. After examining Mr Rigg in the 'cage', the FME, according to his own statement, suspected a heart attack or excited delirium and requested that an ambulance be called. Having returned to his room to write up his notes, he was recalled after three to five minutes by the custody sergeant shouting that the man (i.e. Mr Rigg) had stopped breathing. **It is hard to understand why the FME went away from a man in Mr Rigg's condition to write up his notes while an ambulance was awaited.** Not only did the presence of the FME fail to result in immediate access to medical assessment or care, but also, when the FME did become involved with Mr Rigg's situation, his assessments and actions did not correspond to the unfolding crisis. As the deterioration in Mr Rigg's health became acute, the police officers who apprehended Mr Rigg, while not absolved of their responsibility for his care, would understandably feel that the responsibility was shared with both the medical professional at the station and with the custody sergeant.

According to his statement to the IPCC, having returned to the 'cage', the FME checked Mr Rigg and found no chest movement. The emergency treatment provided to Mr Rigg is difficult to see on the CCTV footage, as the view of the 'cage' is blocked by the backs of various police officers. It is clear from the FME's own statement, and police officers' accounts, that the FME was observing rather than leading these efforts. The CCTV footage shows the FME hovering in the custody corridor and moving back and forth on the fringes of the CPR activity carried out by various police officers. **The ambulance staff reportedly considered the officers had done a good job of trying to resuscitate Mr Rigg.**

The FME's actions drew strong criticism in the Commissioner's Foreword to the IPCC investigation report: "we were so concerned about the action (or inaction) of the forensic medical examiner (FME) that we reported him to the General Medical Council. He resigned shortly afterwards."[11] **The Review considers that, in the absence of a judgment by the General Medical Council (GMC), the IPCC report would have been justified in finding that the FME had failed in his duty of care.**

The Review welcomes the considerable advances in the training of forensic doctors working in police settings since the death of Mr Rigg in August 2008 and, in particular, the programmes developed by the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London.

Call handling

The IPCC investigation examined the 999 calls in detail. It showed how they were handled and identified some interesting insights into the system used to classify calls according to their degree of urgency, the variations in and clarity of guidance for call handlers, the amount and content of information provided to callers, and local average police response times.

[11] IPCC, Commissioner's Foreword: IPCC investigation report Sean Rigg, 15 August 2012. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

The one call about which the IPCC came to a negative conclusion was, ironically, the last call made by the hostel manager, who was not at the hostel at the time and, therefore, was not aware that, by the time she made the call, Mr Rigg had been arrested and was arriving at Brixton Police Station in the police van. The IPCC response to her complaint about the call operator she dealt with had no bearing on the death of Mr Rigg.

The far bigger issue was that the hostel made a total of five calls but it took the police three hours and nineteen minutes to attend the hostel, by which time Mr Rigg had just collapsed at Brixton Police Station. The IPCC concluded that "As tragic as the circumstances turned out to be for Mr Rigg and his family on 21 August 2008, the speed of the police response to the calls for help was not exceptional or even out of the ordinary." Statistically this is accurate. As the IPCC investigation established, the average police response time in Lambeth to calls classified as the hostel calls were was three and a half hours, although the MPS target time for response to such calls is one hour. This highlights the need to review both police resources for responding to emergency calls and methods for improving the call operating system. The IPCC report concluded, in what reads like an *apologia*, that "Unfortunately, in many circumstances it is just not possible for the police performance to match up to the often unrealistic public expectation of them." The Review considers that more robust criticism might have been expected from the IPCC report.

The Review considers that the call operators would have better understood the gravity of the unfolding situation if the hostel where Mr Rigg was living had been flagged on the police information system as an exclusively forensic facility: all its residents had mental health problems and histories of offending. In addition, if multi-agency public protection arrangements (MAPPA) had been in place as regards Mr Rigg, this would also have been flagged on the police information system: prompt action would then have been more likely in the event of a mental health relapse.

The Review considers it good practice for every local MAPPA team to identify all placement locations for offenders with mental health problems; this would ensure that these facilities are highlighted for the purposes of emergency call operators. This would facilitate appropriate classification of emergency calls and contribute to a prompt response.

The IPCC report could have identified these gaps and the need for better communications and contingency planning across agencies in relation to people, like Mr Rigg, who are living in community care and who represent a risk both to themselves and others when their mental health condition deteriorates. If the police had responded to the hostel's calls sooner, they would have been dealing with Mr Rigg in a mental health setting, with hostel staff at hand.

Community mental health care

The IPCC report's chronology of events points towards, but does not clearly identify, the failures of community health services (i) to plan for relapse, (ii) to properly assess Mr Rigg as he moved through the process of relapse, and (iii) to take effective action to avert the crisis on 21 August 2008. The Review considers that more emphasis might have been placed, in the IPCC investigation, on key features of the community mental health care provided to Mr Rigg. The IPCC report correctly indicates that Mr Rigg had ceased to take his medication and that this, together with increasing signs

in his behaviour of mental health deterioration, were a recognised feature of his relapse cycle. The IPCC investigation did report that there was no recent risk assessment of Mr Rigg by the Forensic Community Mental Health Team (FCMHT) and, in particular, no assessment during his period of relapse. It would have been useful for the IPCC report to have highlighted (i) the lack of a detailed relapse plan, including practical steps to be taken in the event of deterioration in Mr Rigg's condition, (ii) the absence of MAPPA, and (iii) the fact that the hostel was not flagged as a forensic facility.

The Review team understands the reluctance of mental health professionals to take coercive steps that might undermine the therapeutic relationship, but the decision lay firstly with the health professionals rather than the police, who are often in the invidious position of having to 'pick up the pieces' when other agencies are slow to act. During an earlier stage in his relapse, Mr Rigg might have been once again transferred to hospital under the Mental Health Act (MHA) by the FCMHT. Similarly, if more detailed relapse planning had been in place, the hostel staff might have asked the police to assist with using a civil MHA section. Contact with the police would then have occurred in a mental health setting, instead of occurring on the street.

The Review takes the view that better risk assessment, relapse planning, and care plans should be expected of specialised FCMHTs. Mindful of the differences in specialist service delivery across the country, the Review welcomes the review of community forensic services being carried out by the Royal College of Psychiatrists.

The IPCC investigation did not have the benefit of advice from a community mental health expert, as the Review did. **Given the incidence of mental health problems among people who die in police custody,[12] it is important for the IPCC to be able to draw upon mental health expertise in its work. The Review understands that this is now beginning to happen through the use of external experts working on a consultancy basis. The Review recommends that the IPCC consider assessing its need for expert mental health input both by analysing the frequency of cases in which a mental health perspective would have assisted and by assessing past cases as to the level of seriousness of mental health concerns and risks.**

The jury's narrative verdict at the Coroner's Inquest

In his summation, the Coroner ruled that it would not be safe for the jury to find unlawful killing on the evidence cited[13]and also ruled out a verdict of neglect by South London and Maudsley National Health Trust (SLaM) or by the MPS. [14] On the Coroner's advice, the jury considered whether there were defects in the system that contributed to the death, whether there were any other factors relevant to the circumstances of death, and whether these contributed more than minimally or negligibly or trivially to Mr Rigg's death, based on the balance of probabilities.

[12] The Review notes that "almost half of those who died in, or shortly after leaving, police custody in 2011-2012 were identified as having mental health problems". IPCC, Commissioner's Foreword: IPCC investigation report Sean Rigg, 15 August 2012.
[13] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 27 July 2012 transcript, p.4.
[14] Coroner's Inquest, 27 July 2012, transcript p.6.

The jury found *inter alia* a series of failures in the care provided to Mr Rigg by the SLaM clinical team and/or at the hostel, and inadequacies in communications, assessment and crisis planning. As regards the police, the jury found a lack of sufficient and effective communication within the police, an unsuitable level of force used during restraint, a lack of leadership leading to failure to take effective control of the arrest and restraint situation, and an unnecessary length of restraint in the prone position. The majority view of the jury was that the length of restraint in the prone position more than minimally contributed to Mr Rigg's death. The jury's narrative verdict also identified a failure by the police to identify Mr Rigg as a vulnerable person at the point of arrest, a lack of care while he was inside the van at the police station, a lack of assessment of his physical and mental condition by the police, a failure to follow the standard operating procedure relating to mental health, and unnecessary and inappropriate retention of restraint. The jury found that an absence of appropriate care and urgency of response by the police when he was in the 'cage' of the police station more than minimally contributed to Mr Rigg's death.

There will often be differences between the verdict of a Coroner's Inquest jury and the conclusions of an IPCC report in relation to a death in police custody. However, there should be synergy between the two sets of findings. In the case of the death in custody of Mr Rigg, the conclusions are in striking contrast.

The conclusions of the IPCC report

The conclusions in the IPCC report do not address all the concerns indicated, or implied in, its own narrative; this points to a lack of management support to ensure a robust analysis of the evidence. The Commissioner's Foreword contains a clear, short statement about omissions in community health care and policing in connection with the death of Mr Rigg. However, this sits somewhat oddly with the body of the report, which draws conclusions in relation to specific complaints, and ends by reaching only two findings in response to the Rigg family's array of questions.

The more important of the two findings was that "the officers adhered to policy and good practice by monitoring Mr Rigg in the back of the van whilst being transported to Brixton Police Station following his arrest".[15] There was no CCTV in police vans at the time, although happily Lambeth is now piloting this. The four officers described Mr Rigg as spinning around, rotating or 'walking his legs' around the cage walls, as he lay on his back in the footwell, with his hands cuffed behind his back. **The Review considers that such spinning or rotating would be impossible in practice, given the internal dimensions of the cage.**

The position in the footwell that the officers described would have been uncomfortable, if not painful, particularly for a person handcuffed in the rear stack position. At the speed registered for the van (reaching sixty-three miles per hour), as it sped with blue lights on back to Brixton Police Station, the position would have put Mr Rigg at risk, particularly as he would have been less able to protect himself from injury with his hands cuffed behind his back. The police officers made no reference to moving Mr Rigg into a safer position. An alternative explanation for Mr Rigg's reported movement is that he could have been attempting to adopt a more comfortable position to enable

[15] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 641. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

easier breathing but found it impossible to extricate himself, due both to being restrained and to the confined space.

The officers also reported that he continued not to speak; one officer reported that he gave occasional grunts and groans. The police officers also stated that they still did not recognise Mr Rigg as having mental health problems. **The Review recommends that the IPCC reconsider this finding.**

The other finding in the IPCC report was that the CCTV at Brixton Police Station was not in full working order at the time of Mr Rigg's death: in this respect, the IPCC considered that the management of the system was inadequate. The IPCC investigation examined the CCTV system and discovered that part of Brixton Police Station was not covered by CCTV and that maintenance and repair arrangements were problematic; an external CCTV camera covering the holding area was no longer in place and two cameras were not recording on 21 August 2008, while a third was giving a very poor picture. **A valuable contribution of the IPCC report was the recommendation regarding improving the system of checks on all police CCTV.** The Review notes that the system in Brixton Police Station was not repaired for some time after Mr Rigg's death,[16] but understands that progress has since been made to comply with the IPCC recommendation. **Effective monitoring of custody is an important safeguard for both the police and the public. There is an obligation to maintain CCTV systems in proper working order; failure to do so without reasonable cause may amount to a breach of management obligation.**

The IPCC and the Rigg family

Contact between the IPCC and the family of a person who has died in police custody is bound to occur under highly stressful circumstances; relations established when feelings about the tragedy are raw will affect subsequent communications. There is an important need for good communications and for information to be given repeatedly and sensitively, taking into account shock and bereavement. The records show a series of communications between the IPCC's family liaison manager (FLM) and the Rigg family. The paperwork involved is considerable in quantity; it would seem that the problems related rather to quality.

The initial press release reported Mr Rigg as dying in hospital, whereas Mr Rigg was pronounced dead soon after arrival at the hospital. The Commissioner subsequently apologised for this. **The presumption should be that the press release about a death in custody should be agreed with the family or their representative.** Problems regarding access to information also played a part in alienating Mr Rigg's family. **The family of a person who has died in custody is entitled to access to all relevant information, including medical information. The Review recommends this as the default position; exceptions should be only for compelling reasons.**

[16] Expert report to the IPCC, IPCC report R9L. Mr Thorne notes that on 2 March 2009 Cameras 18 and 3 were "still not working properly".

The Rigg family first met the Commissioner overseeing the case in January 2009. **It should be standard practice for the Commissioner to invite the family to meet with him or her soon after a death in custody.** The invitation, if conveyed orally, should also be repeated in writing.

The Review was concerned to find that the IPCC documents include police national computer (PNC) records for two members of Mr Rigg's family.[17] The IPCC had requested the PNC records relating to the main witnesses to the arrest, but not for the Rigg family, who did not witness the events surrounding Mr Rigg's death. The Review has not viewed the content of these records and considers it inappropriate for this information to have been sent by the MPS to the IPCC. After the death of Mr Rigg, his family should have been considered as akin to victims – as should the family of any person who dies in custody, unless the family is involved in the events leading to the death. **In order to avoid unjustified provision of confidential information from the MPS to the IPCC, any such material sent to the IPCC should be sent back with a request for an explanation of the action and a clear indication that the IPCC considers it inappropriate to receive such information.**

It appears that the senior investigator viewed the PNC records of the two members of the Rigg family in the context of a risk assessment related to the family's viewing of the Brixton Police Station CCTV. On the information available to it, the Review considers that it was not necessary or proportionate for the senior investigator to view the contents of the PNC records of members of the Rigg family in this context. Data held on the PNC will almost invariably amount to sensitive personal data.[18] The Review fails to see the relevance of processing the sensitive personal data of members of the Rigg family; such processing may have been in breach of data processing principles.

The perspective of the family of someone who has died in custody is obviously not impartial and, thus, is necessarily different from that of the IPCC. The Review considers that the family are fellow travellers in the search for the truth; the perspective of the family must be recognised as important. The Rigg family were determined to see that a thorough investigation took place. Their considerable and sustained efforts resulted in the emergence of information that might otherwise not have seen the light of day. The Rigg family are to be commended for their tenacity and commitment in this regard. This Review has benefited significantly from the input of members of the Rigg family and their solicitors.

IPCC independence and the role of Commissioners

All members of the IPCC need to ensure the independence of their work and that of the organisation as a whole. According to the legislative framework, the ultimate guarantors of independence are the Commissioners. There is a need to ensure that they can exercise their duty of oversight in practice. The Review notes that the Commissioner in charge of the investigation into the death of Mr Rigg was the only member of the IPCC team on the case who was not located in London;[19] this had implications for effective oversight.

[17] IPCC documents D65 and D68, listed on 3 September 2008.
[18] Data Protection Act 1998, section 2.
[19] At the time, London cases were at times allocated to Commissioners outside London. This practice changed in 2009 when London cases were allocated only to a core team of south-east based Commissioners.

It is for the IPCC Commissioner overseeing an investigation to sign off on the report; therefore, it is the Commissioner who is ultimately responsible for the report as a whole. The Review believes that this requires a more 'hands on' approach from Commissioners than was the norm in 2008, including ensuring that investigations are properly managed by senior staff and that there is a strategic approach to addressing the key issues.

The Review understands that developments in this direction are already underway and some significant changes have already been effected. In particular, the Review notes the recent agreement (in February 2013) on new guidance on the Commissioner role in independent investigations.[20] **This is a welcome development.** The new guidance provides for an updated IPCC delegation scheme and specific arrangements in all critical incidents, including the establishment of a Critical Incident Management Team (CIMT). The Review considers that the death of Sean Rigg would have qualified as a critical incident meriting the establishment of a CIMT.

If the IPCC report on their investigation into the death of Mr Rigg were being drafted today, the Review considers that the Commissioner should be expected both to oversee analysis of the information gathered by the investigating team and to work with senior managers to develop a set of more robust findings and conclusions, indicating the major concerns to be addressed by the Coroner. These concerns might have included possible lapses in the duty of care by those providing care in the community and by the police, as well as the need for improved arrangements to ensure cross-agency co-operation in the event of relapse on the part of individuals with mental health problems, especially those with a history of offending. The Review considers that the IPCC would have been within its remit to identify implications (i) for improved communications between agencies, as well as within the police, (ii) for police training, and (iii) for more detailed standards as regards recognising and responding to people with mental health problems. **The Review recommends that, in relation to future deaths in police custody, the IPCC look not only at police involvement in the circumstances surrounding the death but also more widely at other issues, including the possible contribution of other agencies to the circumstances surrounding the death before contact with the police.**[21]

Limitations on the IPCC

It is clear that the IPCC investigation was hampered by limitations, some unavoidable and others that might have been minimised. One of the unavoidable limitations is the need to rely on the police in the period immediately following a death in custody. Keeping this reliance to a minimum has clear resource implications, not only as regards having IPCC staff on call and the logistics of a rapid response, but also in terms of the expertise needed.

When the IPCC first arrived at Brixton Police Station on 21 August 2008, the Metropolitan Police Department of Professional Standards (DPS) had undertaken to appoint a crime scene manager; the

[20] IPCC, Commissioner role in independent investigations, February 2013. Available at http://www.ipcc.gov.uk/Commission documents/Item 14 - Commissioner Role in Independent Investigations [NPM].PDF.

[21] See *Reynolds, R (on application of) v. IPCC & Anor* [2008] EWCA Civ 1160, [2009] 3 All ER 237, [2009] PTSR 1229, [2009] ACD 51, para. 25.

IPCC does not have the resources to appoint their own crime scene managers and it is established practice to rely on the police for this function.

Securing evidence, including securing the scene of the incident and ensuring that separate accounts are provided promptly by key individuals, are matters best handled without delay. The Review found that on these matters there were problems with the IPCC investigation from the very outset. **The Review recommends that detailed protocols be developed with all police services, spelling out the duty of the DPS, in the absence of the IPCC, to safeguard the public interest concerning deaths in custody. It is important that the IPCC take control as soon as possible.**

The scene of Mr Rigg's arrest was not secured, even though it was noted that there was no CCTV covering that area. The Review agrees with the IPCC's own internal review of the investigation that the scene of arrest and restraint could have been preserved and considers that this should have been done. **The Review considers that best practice required securing the scene and that the police were open to criticism for not following best practice.** This problem is symptomatic of the difficulties facing the IPCC at the outset of an investigation into a death in police custody; **the IPCC is not present at the very start and must rely on the police, who are on the spot and whose full cooperation they have a right to expect.**

Statements were made on the night of 21/22 August by only three of the four officers involved in Mr Rigg's arrest, restraint, transportation, and detention at the police station. At the Coroner's Inquest, the fourth officer stated that he had been advised not to make a statement by the Police Federation and a solicitor for the police. Every individual has the right to remain silent, but that silence may be taken into consideration later in legal proceedings. The IPCC investigation report does not highlight the fact that only three police officers made initial statements.

Of serious concern is the fact that the four police officers were not kept separate during the night of 21/22 August. The IPCC investigation report makes no reference to this and it only emerged at the Coroner's Inquest that the four officers were initially separate, but were then placed together for more than an hour, with a member of the MPS, before a joint meeting in the early hours of 22 August involving the IPCC, the DPS, the police officers, PF representatives, and others. The Review does not understand the reasons given for this, including that the IPCC team were only observers at the joint meeting because the decision as to the mode of investigation was not made until later that morning. The Review notes that the IPCC documentation does not contain a full and clear record of the joint meeting.

The Review considers that, in the interests of an effective investigation, the arresting police officers should have been separated and instructed not to speak or otherwise communicate with each other about the events until the IPCC was able to take detailed initial statements from each. This should be standard practice in cases of deaths in police custody. Such a safeguard would not preclude any necessary support being provided to each officer individually by appropriate other people.

As regards obtaining evidence from those police officers most nearly involved in the events surrounding a death in police custody, there is a clear tension between the due process rights of any person and the duty of a police officer; as agents of the State, police officers share the obligation to

protect life and to ensure an effective investigation of any death in police custody. As one former senior police officer put it, "Any police officer worth his salt will be ready to tell the truth and cooperate with the IPCC." It appears to the Review that full cooperation from the police is not always the case. The Review welcomes the fact that the IPCC has now been granted the statutory power to require officers to attend for interview. The IPCC cannot compel officers to answer questions, but it is clearly the legislative intent that the police should cooperate fully with an IPCC investigation.

Securing evidence promptly

The IPCC did not interview the four officers until the second half of January 2009, and then only as regards the specific allegations of assault it had received. It was not until the second half of March 2009 that the four officers, and the custody sergeant on duty at Brixton Police Station, were interviewed more fully about the circumstances surrounding the death of Mr Rigg. Reasons given for this delay of several months included the IPCC's changing view of the status of the officers concerned: whether they were to be treated as witnesses, special witnesses, or suspects, and the wish not to have to interview the officers more than once. In fact, the police officers were eventually interviewed twice.

The Review finds the delay in interviewing the officers unwarranted. The Review considers, like the internal IPCC review, that the issues should have been resolved speedily through senior consultation within the IPCC so that the officers could be interviewed promptly after the death of Mr Rigg. **The Review recommends that it be standard practice in cases of deaths in police custody for interviews with key police officers to be carried out as soon as reasonably practicable.**

The IPCC's role

After almost ten years in existence, it is time to take stock and reconsider the IPCC's role. The classic reflex of complaints authorities is to focus on complaints. However, when there is a death in custody, the IPCC investigation does not depend on a complaint: the remit of the IPCC goes beyond investigating and responding to individual complaints. In cases of death in custody, the public has an interest in, and an expectation of, the IPCC: it expects the IPCC to fulfil its guardianship role and test whether the State has met its obligations arising from Article 2 of the European Convention on Human Rights (ECHR): to protect the right to life. In accordance with the jurisprudence of the European Court of Human Rights (ECtHR), the United Kingdom is obliged to ensure effective fillinvestigation into deaths in custody in order to provide an effective remedy in law and to prevent such an event from happening again. The IPCC's role encompasses that duty. The IPCC fulfils that duty by looking into all the circumstances of an individual's death in police custody effectively and thoroughly, and deriving lessons for the improvement of safeguards. The public expects nothing less.

The requirements of a truly independent and effective investigation derive from the case law of the ECtHR. In accordance with the judgments in *Jordan v. United Kingdom*[22] and *Edwards v. United*

[22] *Jordan v. United Kingdom* [2001] 37 EHHR 52, paras 105-109.

Kingdom,[23] the investigation should (i) be set up by the State of its own accord (without requiring any complaint or allegation), (ii) be independent practically and hierarchically, (iii) be effective in the sense of capable both of determining the legality of the State's actions or omissions and of leading to the accountability of those responsible (including by criminal prosecution), (iv) be prompt and reasonably expeditious, (v) have sufficient public scrutiny to ensure effective accountability in practice as well as in theory, and (vi) should have sufficient involvement of the next of kin to ensure their legitimate interests.

Translating this into effective working methods is complex. The targeted objectives of an individual investigation into a death in custody include establishing the truth, identifying possible criminal offending, identifying possible misconduct, and identifying failures of individuals and of the system, even if these do not reach the threshold of criminal offence or misconduct.

The preventive role of the IPCC requires a more proactive and holistic approach to understanding the circumstances surrounding deaths in custody. By identifying gaps and practical shortcomings in individual cases, the IPCC is in prime position to identify patterns of systemic weakness across cases and, thus, to recommend changes to policy and operations in order to prevent recurrence.

The standards to be applied by the IPCC

For the IPCC, there is also the matter of holding the system to account. The Review suggests that it is part of the IPCC's role to review police regulations, procedures, and guidance, and to identify any shortcomings. The key questions are what should reasonably be expected of the police in the circumstances and whether compliance with police guidance adequately reflects the duty of care to people in police custody. If the IPCC's role is limited to assessing officers' actions against criteria and standards derived from the police guidance applicable at the time, this will produce an external audit of police work in cases where a death or serious injury occurs, or when there is a complaint to be answered. Auditing is an important function, but arguably the public has the right to expect more of the IPCC.

This implies that the IPCC should develop its own criteria for assessment. **The Review recommends that the IPCC develop, and articulate for IPCC staff, clear expectations and independent criteria for assessing police conduct.** Ultimately, the test is whether or not policing policy and practice complies with human rights jurisprudence and standards for combating impunity.

Methodology

Interviews with police officers involved in the circumstances surrounding a death in custody are highly sensitive and complex. The tapes of the March 2009 interviews with the police officers involved in Mr Rigg's death were not transcribed until needed for the Coroner's Inquest. The IPCC had to rely on notes from the interviews and the tapes themselves. Given the considerable cost of transcription, arrangements might be considered for sharing the expense across the IPCC and

[23] *Edwards v United Kingdom* [2002] 35 EHHR 19, paras 69-73.

coroners' inquests; transcripts should be made promptly, to ensure maximum benefit during investigations, including as regards facilitating case management and oversight, as well as at coroners' inquests. **The Review recommends that it be standard practice to transcribe interviews promptly in investigations into deaths in custody.** In the absence of transcripts, continuity of interviewers was particularly important for recall and analysis: the Review notes a lack of continuity across the key interviews. **The Review recommends that continuity be considered a priority in future investigations.**

There is a need for the IPCC to look analytically at the substantive and methodological issues arising in a single case and across cases. In the past there appears to have been a lack of IPCC follow-up across cases. **The Review recommends that IPCC investigations become part of an iterative process, so that there can be sustained organisational learning.** The Review welcomes the new structures and practices being developed to this end.

The Review suggests that the IPCC give thought to developing a system for storing information in an analytical way, so that it can be searched and used for analytical purposes (e.g. to compare and contrast cases, to establish patterns, and to identify recurring issues). Such a system could also be useful for reviewing IPCC methods through a combination of reflective practices and on-going training. The Review understands that the new guidance agreed in February 2013 includes provision for planning and team debriefing.

The Review recommends multi-disciplinary training and team-building involving legal advisers and experts in specialised fields (e.g. mental health, restraint, and information technology). On-going training is also necessary on technical matters (e.g. interviewing for IPCC investigations). Training for investigators would promote consistency, particularly in terms of interviewing. IPCC interviewing demands methods different from police interviewing: the focus should be on preparation and adoption of an analytical strategy to address key issues, robust questioning, pursuing the implications of answers (including what is left unsaid), and probing the basis of an account and the attitudes behind it.

Resources

Many of the suggestions flowing from the Review have resource implications, though the question of resources has not been the focus of this Review. It is impossible not to recognise the severe resource limitations under which the IPCC is constrained to operate. The Review recommends that these limitations be reviewed and remedied. The Home Affairs Committee has addressed this incisively: "Compared with the might of the 43 police forces in England and Wales, the IPCC is woefully underequipped and hamstrung in achieving its original objectives. It has neither the powers nor the resources that it needs to get to the truth when the integrity of the police is in doubt. Smaller even than the Professional Standards Department of the Metropolitan Police, the Commission is not even first among equals, yet it is meant to be the backstop of the system. It lacks the investigative resources necessary to get to the truth; police forces are too often left to investigate themselves; and the voice of the IPCC does not have binding authority. The Commission must bring the police

complaints system up to scratch and the Government must give it the powers that it needs to do so."[24]

Key Considerations and Recommendations

The IPCC's role

In cases of death in custody, the public has an interest in, and an expectation of, the IPCC: it expects the IPCC to fulfil its guardianship role and test whether the State has met its obligations arising from Article 2 of the European Convention on Human Rights to protect the right to life. In accordance with the jurisprudence of the European Court of Human Rights, the United Kingdom is obliged to ensure effective investigation into deaths in custody in order both to provide an effective remedy in law and to prevent such an event from happening again. The IPCC's role encompasses that duty. The IPCC fulfils that duty by looking into all the circumstances of an individual's death in police custody effectively and thoroughly, and deriving lessons for future improvement of safeguards. The public expects nothing less.

The Review considers that the preventive role of the IPCC requires a more proactive and holistic approach to understanding the circumstances surrounding deaths in custody than was in place in 2008. By identifying gaps and practical shortcomings in individual cases, the IPCC is in prime position to identify patterns of systemic weakness across cases and, thus, to recommend changes to policy and operations in order to prevent recurrence.

Scope of IPCC investigations

The Review considers that, when a death in custody occurs, the public has an interest not only in knowing whether any crime or misconduct has occurred, but also in understanding what has happened and why; this is especially important when there are lessons to be learnt to prevent further tragedies.

The Review recommends that, in relation to future deaths in police custody, the IPCC look not only at police involvement in the circumstances surrounding the death, but also more widely at other issues, including in relation to the contribution of other agencies to the circumstances surrounding the death before contact with the police.[25]

A report from the IPCC must be expected to raise questions to be addressed by others, such as the Coroner, and to draw robust conclusions not only as to whether misconduct or criminal behaviour occurred, but also as to whether there was poor practice or whether there were omissions in the duty of care, constituting at least poor practice and possibly amounting to a breach of the duty of care.

[24] Home Affairs Committee, Eleventh report: IPCC, 29 January 2013, para.5. Available at http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/49402.htm.
[25] See *Reynolds, R (on application of) v. IPCC & Anor* [2008] EWCA Civ 1160, [2009] 3 All ER 237, [2009] PTSR 1229, [2009] ACD 51, para. 25.

Issues for the IPCC in the light of the Coroner's Inquest in the case of Sean Rigg

The Review recommends that, in light of the important evidence emerging at the inquest, the IPCC reconsider the issue of restraint, including duration of restraint in the prone position.
Based on the accumulated evidence following the inquest, the Review recommends that the IPCC reconsider the conduct of the police officers involved in the apprehension, restraint and detention of Mr Rigg in relation to possible breaches of their duty of care, with a view to determining whether to bring misconduct proceedings.

In the light of the evidence emerging at the inquest, the Review also recommends that the IPCC look again at whether the officers (i) moved Mr Rigg promptly from restraint in the prone position and assessed him adequately, as soon as he was brought under control, (ii) ignored clear signs that he was mentally unwell, (iii) took steps to ensure his safety and well-being during the time when he was locked inside the van's cage and confined in the footwell, while cuffed in the rear stack restraint position, and (iv) provided him with prompt access to medical attention.

The evidence emerging at the inquest demonstrated that Mr Rigg was not visited in the van, while it was parked in the yard of Brixton Police Station, by either the custody sergeant or the doctor; the Review recommends further consideration by the IPCC of the care provided to Mr Rigg on his arrival at Brixton Police Station. The IPCC may wish to reconsider whether or not there was due care for Mr Rigg's safety and well-being on arrival in terms of (i) a prompt risk assessment, (ii) a prompt assessment of his medical needs (including his physical and mental health needs), and (iii) prompt provision of medical attention.

Critical analysis

The final IPCC investigation report is, in essence, a narrative investigation report drawn primarily from the accounts given by the four police officers present during the important events, as well as examination of formal complaints made by the family and by the hostel manager, and also detailed scrutiny of the CAD calls and the CCTV system. What is missing is a sufficiently critical analysis of the information presented.

The Review considers that, at the very least, the IPCC report should have raised concerns (for future examination by the Coroner or others) as to (i) the plausibility of the police officers' accounts of their handling of Mr Rigg's passport (discovered when Mr Rigg was searched upon arrest), and (ii) their failure to identify Mr Rigg using this piece of concrete evidence.

The Review considers that there were a number of concerns that could and should have been raised in the IPCC report: (i) the position adopted by the officers that they were not aware that Mr Rigg might be suffering from mental health problems was open to question on the grounds of improbability, given the clear indications of mental illness enumerated in the report; (ii) if the police officers did not suspect that Mr Rigg was mentally ill, it was open to question whether they were observing him carefully enough and assessing him on an on-going basis; and (iii) the omissions and/or failures of the police officers in relation to identifying Mr Rigg as a person with mental health issues were indicative of a lack of care towards Mr Rigg as a person in their custody.

The IPCC notes that the police response time to the 999 calls from the hostel was far outside the standard established for police attendance. This deserved to be firmly criticised by the IPCC. If the police had arrived within two hours of the first 999 call from the Penrose Hostel, Mr Rigg would still have been at the hostel and the scenario would have been significantly different: both police and hostel staff would have been present, his mental health issues would have been known, and, in all probability, he would have been processed under the Mental Health Act and taken to receive immediate medical attention.

Since checking CAD information is standard practice when operating in response to a CAD call, more robust criticism in the IPCC investigation report might have been expected about the officers' failures to carry out these important checks, which would have revealed markers for Mr Rigg's psychiatric history, as well as his past offending (including violence) during relapses in his mental health condition.

The Review considers that the IPCC should have addressed the issue of race, as included in the terms of reference of the investigation. The lack of reference to race throughout the report is not a sign of non-discrimination, but rather an indication of malaise and/or lack of confidence about how to address racial issues appropriately.

The Review recommends that the IPCC develop, and articulate for IPCC staff, clear expectations and independent criteria for assessing police conduct.

Mental health issues

The Review recommends that future IPCC investigation reports regarding deaths in custody involving mental health issues give more attention to missed opportunities to provide care before crisis involvement with the police. The Review suggests that, in future, IPCC investigations should examine Multi-Agency Public Protection Arrangements (MAPPA) in all cases of death in custody of persons with a mental health condition and offending histories involving risk of harm to others.

There was a clear need for co-ordination between the police and the community mental health services to ensure that the police were aware of the status of the hostel at Fairmount Road. The Review welcomes the Lambeth Safeguarding Adults Partnership Board's indication that placement for forensic clients will be reviewed and incorporated into the police call centre system.

Looking forwards, the Review recommends that, in IPCC investigations of deaths in custody involving mental health service users, there is a clear expectation that partner services, health services, probation services, social work services, voluntary sector organisations, and others will share information at an early point.

Given that almost half of those who died in, or shortly after leaving, police custody in 2011-2012 were identified as having mental health problems,[26] the Review recommends that the IPCC consider assessing its need for expert mental health input, both by analysing the frequency of cases in which a

[26] IPCC, Commissioner's Foreword: IPCC investigation report Sean Rigg, 15 August 2012. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

mental health perspective would have assisted and by assessing past cases as to the level of seriousness of mental health concerns and risks.

Medical care in custody

The Review considers that, in the absence of a judgement by the General Medical Council, the IPCC report would have been justified in finding that the forensic medical examiner at Brixton Police Station had failed in his duty of care towards Mr Rigg.

The Review welcomes the considerable advances in the training of forensic doctors working in police settings since 2008 and, in particular, the programmes developed by the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London.

The duty of the police in relation to the IPCC

When there is a death in custody, the IPCC is not present at the outset and must rely on the police, who are on the spot and whose full cooperation they have a right to expect.

The Review considers that the IPCC should have taken overall control of the investigation immediately. The Review understands that today an IPCC investigation into a death in custody would always be an independent investigation. The Review recommends that this change since 2008 be formally and unequivocally established in IPCC guidance.

The Review recommends that detailed protocols be developed with all police services, spelling out the duty of the relevant Department of Professional Standards (as designated in the Metropolitan Police Service), in the absence of the IPCC, to safeguard the public interest concerning deaths in custody.

The Review considers that best practice required securing the scene and that the police were open to criticism for not following this best practice.

The Review considers that, in the interests of an effective investigation, the arresting police officers should have been separated, until the IPCC was able to take detailed initial statements from each, and that they should have been instructed not to speak or otherwise communicate with each other about the events. The Review recommends that this be standard practice in cases of death in police custody. Such a safeguard would not preclude any necessary support being provided to each officer individually by appropriate other people.

The Review recommends that it be standard practice in cases of death in police custody for interviews with key police officers to be carried out as soon as reasonably practicable.

The Review considers that the IPCC has a right to expect all police officers to cooperate in investigations into deaths in custody; the presumption must be (i) that they will make notes as soon as possible of any important matters, without conferring, and (ii) that they will provide initial

statements to the IPCC, also without conferring. All individuals, including police officers, have the right not to incriminate themselves; however, the decision to remain silent may be noted and taken into account in any subsequent proceedings. If, on advice, a police officer does not provide an initial statement for the IPCC, this fact should be included in the IPCC's investigation report.

The Review welcomes the fact that the IPCC has now been granted the statutory power to require officers to attend for interview. The IPCC cannot compel officers to answer questions, but it is clearly the legislative intent that the police should cooperate fully.

Effective monitoring of custody is an important safeguard for both the police and the public. There is an obligation to maintain CCTV systems in proper working order; failure to do so without reasonable cause may amount to a breach of management obligation.

IPCC and the family

The presumption should be that the press release about a death in custody should be agreed in advance with the family or their representative.

The family of a person who has died in custody is entitled to access to all relevant information, including medical information. The Review recommends this as the default position; exceptions should only be made for compelling reasons.

It should be standard practice for the Commissioner to invite the family to meet with him or her soon after the death in custody. The invitation, if conveyed orally, should also be repeated in writing. If the family feels unable to meet in the immediate period after the death in custody, the invitation should be reiterated in writing at intervals to ensure that the family has, and is aware of, the opportunity to meet with the Commissioner as soon as the family wishes to do so.

In order to avoid unjustified provision of confidential information from the Metropolitan Police Service to the IPCC, any such material sent to the IPCC should be sent back with a request for an explanation of why it was sent and a clear indication that the IPCC considers it inappropriate to receive such information. The Review fails to see the relevance of processing the sensitive personal data of members of the Rigg family; such processing may have been in breach of the data processing principles.

IPCC methodology

The Review believes that a more 'hands on' approach from Commissioners than was the norm in 2008 is required; the Commissioner should ensure that investigations are properly managed by senior staff and that there is a strategic approach to addressing the key issues. The Review

understands that developments in this direction are already underway and welcomes new IPCC guidance (agreed in February 2013) on the commissioner role in independent investigations.[27]

The Review recommends that the IPCC, police and the Police Federation agree detailed protocols about the role of the Police Federation representative, and what is acceptable conduct at IPCC interviews.

The Review recommends that it be standard practice to transcribe interviews promptly in investigations into deaths in custody to ensure maximum benefit during investigations, including as regards facilitating case management and oversight. The Review recommends that continuity of IPCC staff in investigations and in key interviews be considered a priority in future investigations.

The Review recommends that IPCC investigations become part of an iterative process, so that there can be sustained organisational learning. The Review welcomes the new structures and practices being developed to this end.

The Review suggests that the IPCC give thought to developing a system for storing information in an analytical way so that it can be searched and used for analytical purposes (e.g. to compare and contrast cases, to establish patterns, and to identify recurring issues). Such a system could also be useful for reviewing IPCC methods through a combination of reflective practices and on-going training. The Review understands that the guidance agreed in February 2013 includes provision for planning and team debriefing.[28]

The Review recommends multi-disciplinary training and team-building involving all levels of the IPCC, including legal advisers and experts in specialised fields (e.g. mental health, restraint, and information technology). On-going training is also necessary on more technical matters.

The Review recommends further development of training of investigators, including as regards preparation and planning for interviews, as well as interviewing methods. The Review also recommends further training of senior staff in the management of investigations, analytical supervision, and strategic support for the report-drafting process.

The Review emphasises how important it is for the IPCC to be independent and *to be seen* to be independent; the perception of independence is an important factor in public confidence in the IPCC. For the future, this should be borne in mind when choosing *external* experts. The Review recommends that the IPCC ensure that competent expertise is available to IPCC investigations from a wider range of independent experts, including restraint experts.

Resources

The Review recommends that the IPCC's resource limitations be reviewed and remedied.

[27] IPCC, Commissioner role in independent investigations, February 2013. Available at http://www.ipcc.gov.uk/Commission documents/Item 14 - Commissioner Role in Independent Investigations [NPM].PDF.
[28] IPCC, Revised IPCC Statutory Guidance, 2013. Available at http://www.ipcc.gov.uk/en/Pages/statutoryguidance.aspx.

I. Introduction to full report

This independent external review (the Review) of the investigation conducted by the Independent Police Complaints Commission (IPCC)[29] into the death in police custody of Sean Rigg was carried out by Dr Silvia Casale with Martin John Corfe (a forensic mental health nurse consultant), who advised on matters relating to mental health and security, and with James Lewis QC, who advised on legal aspects of the Review (see Appendix A). The Review has benefited greatly from their invaluable expertise and experience. The findings and conclusions have been shared prior to publication with the Chairperson of the IPCC, Dame Anne Owers, and with the Rigg family, but are the sole responsibility of Silvia Casale.

Mr Rigg died on the evening of 21 August 2008 after a sustained period in police custody: during apprehension, transfer by police van to Brixton Police Station, and detention in the 'cage' holding area there. He was not admitted into the custody suite at the station. During most of this time Mr Rigg was subject to means of restraint.

The IPCC investigation triggered by his death began later that evening. Much of the IPCC's evidence gathering had been completed by the end of January 2009 when an interim report was drafted.

The Coroner's Inquest into the death of Sean Rigg took place almost four years later, between June and July 2012. On 1 August 2012, the jury at the Coroner's Inquest handed down its narrative verdict; this differed in important ways from the conclusions of the IPCC report, published on 15 August. That same day, Dame Anne Owers announced that she would be commissioning an external review of the investigation to identify areas of improvement for the IPCC.

The Review has a wide remit (see Appendix B: Terms of reference for the Review) to look at the IPCC investigation in light of the evidence given at the inquest, as well as at the verdict itself, in order (i) to consider whether any further investigation is required, and (ii) to identify implications for improvements in practice, and in the system for investigating deaths following police contact, with a view to preventing such a tragedy from happening again.

The Review was commissioned on 1 October 2012. The terms of reference for the Review were then discussed with Dame Anne Owers and Jane Furniss, Chief Executive Officer of the IPCC. In early November, Dr Casale met with members of Mr Rigg's family and their solicitors to discuss the terms of reference as well as to learn about their concerns; the Review team has met and communicated regularly with members of the Rigg family and their solicitors throughout the Review period in order to benefit from their knowledge and experience, and to ensure that their concerns were not overlooked.

[29] A list of abbreviations used in this review report can be found in Appendix E.

The approach of the Review

The aim of this Review is to arrive at a clear and honest understanding of the IPCC investigation, drawing out what may be learned in terms of good practice and development options, both as regards substance and methodology, in order to inform future IPCC investigations involving the right to life as provided in Article 2 of the European Convention on Human Rights (ECHR). The Review also makes recommendations concerning the wider system for investigating deaths following police contact, so as to feed into the general review on this subject already underway.[30]

To this end, the Review has involved (i) listening to and analysing accounts from key individuals involved in the investigation and those who came into contact with Mr Rigg immediately prior to his death, and (ii) examining other relevant sources of information (see Appendix C: Persons and organisations consulted during the Review and Appendix D: Selected list of sources). The key aims were to arrive at an independent analytical assessment from an impartial and objective outside perspective, and to produce constructive criticism and recommendations for change based on that assessment.

The Review's task was complicated by the departure of some key IPCC staff members, including the senior investigator responsible for much of the operational investigation, who left the IPCC in 2010, and the forensic medical examiner on duty at Brixton Police Station, who applied to the General Medical Council for voluntary erasure in April 2010. The Review has therefore had to reconstruct the IPCC investigation and, to a certain extent, the events that were the subject of that investigation. Ironically, that process has to some degree mirrored the drafting of the IPCC investigation report, which was written by a senior IPCC investigator who took over the case in February 2009 and so was not involved in the crucial first six months of the operational investigation.[31]

The Review recognises the complexity of IPCC investigations into deaths in custody. It is always easier to look back and make a critical analysis than to analyse critically while actually engaging in the difficult process of investigating a tragic event. The Review's focus is not on apportioning individual blame for past omissions or errors, but rather on ways of improving the system and current practice by learning from the past to prevent a recurrence of what happened to Mr Rigg.

The Review has tried to keep clear the distinction between information available at the time and information emerging only after the death of Mr Rigg; the Review wished to establish, on the one hand, what information key persons involved at the time might reasonably be expected to have had at their disposal and, on the other hand, what lessons can be learnt in the light of all the information now available.

The Review has had the benefit of consultation with a number of on-going initiatives related to the death of Mr Rigg, including the parallel review of health and social care support carried out by

[30] A panel of experts was established in August to advise the IPCC in its review of deaths following police contact. The members of the panel are Lord Dholakia, Deborah Coles (co-director of the charity INQUEST), Professor Mike Hough (co-director of the Institute for Criminal Policy Research), and Matthew Ryder QC.

[31] Two other key members of the original investigation team left the IPCC during the course of the investigation. See IPCC internal review of the Rigg investigation, IPCC document D344.

Lambeth Safeguarding Adults Partnership Board,[32] the wider review of deaths following police contact, and the independent review commissioned by the Metropolitan Police Service (MPS) of mental health and policing (see Appendix D: Selected list of sources).

The Review has taken as its starting point the standards on investigation of human rights violations applicable in the European common legal space, including the jurisprudence of the European Court of Human Rights (ECtHR) and the standards of the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[33]. In accordance with the ECtHR's judgments, effective investigations into possible violations of the right to life and of the prohibition against ill-treatment must be independent, thorough, comprehensive and expeditious, and open to public scrutiny.[34]

[32] The Review was provided with the December 2012 version of the LSAPB report, which was subsequently revised.
[33] CPT, Combating impunity, 14th General report of the CPT, CPT/Inf (2004) 28, paras 25-42. Available at http://www.cpt.coe.int/en/annual/rep-14.htm.
[34] *Case of Dimitrova and others v. Bulgaria*, 44862/04 Judgment (Merits and Just Satisfaction) Court (Fifth Section), European Court of Human Rights, 27 January 2011. Available at http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-103117#{"itemid":["001-103117"]}.

II. The course of the IPCC investigation

At 21.03 hours on 21 August 2008, the ambulance carrying Mr Rigg was recorded as leaving Brixton Police Station. Mr Rigg was pronounced dead at 21.24 hours at Kings College Hospital. Four years later, the narrative verdict of the jury at the Coroner's Inquest recorded the time of death as 20.24 hours. The IPCC was notified[35] by the Department of Professional Standards (DPS) of the Metropolitan Police Service (MPS); the first information appears to have been received by the IPCC at 22.05 hours on 21 August. The first member of the three-person IPCC on-call team to reach Brixton Police Station recorded his arrival time, in handwritten notes, as 23.35 hours. The senior member of the team appears, from the notes, to have arrived at 00.10 on 22 August, having already spoken with IPCC colleagues and the DPS. **This shows good practice on the part of the IPCC in arriving promptly after notification of a death in custody.**

The 'Golden Hour'

It is generally accepted that the time immediately following a serious incident is crucial for an effective investigation. In the police murder manual, this is referred to as the 'Golden Hour', because "effective early action can result in securing significant material that would otherwise be lost to the investigation."[36] Securing evidence, including securing the scene of the incident and ensuring that separate accounts are provided promptly by key individuals, is best handled without delay. On these counts there were problems with the IPCC investigation from the very outset.

The murder manual suggests a fast-track menu of initial tasks regarding (i) the identification of suspects, (ii) intelligence opportunities, (iii) scene forensics, (iv) the crime scene, (v) searching for witnesses, (vi) victim enquiries, (vii) the identification of possible motives, (viii) the media, (ix) the post-mortem, (x) significant witness interviews, (xi) other critical actions, and (xii) passive data opportunities. However, the manual also warns that senior investigators "should quickly review any fast-track actions that are already underway and satisfy themselves that they are well-founded. They should be particularly cautious when fast-track actions have been based on the uncorroborated verbal accounts of witnesses or other informants."[37]

An account of the earliest part of the investigation into the death of Sean Rigg is not given in the IPCC investigation report. The following has been reconstructed from incomplete information available in handwritten notes and a short word-processed report by the on-call team giving an initial assessment on 22 August 2008. **It should be standard practice in any IPCC investigation into a death in custody for detailed notes to be taken legibly (using technological means[38] on the spot, or handwriting and subsequent word-processing) during the first 24 hours. Thereafter, meticulous notes should continue to be taken covering all significant elements of the**

[35] Handwritten notes of members of the IPCC on-call team assigned to the case of Mr Rigg on the night of 21/22 August 2008.
[36] ACPO, Murder Investigation Manual, 2006, Section 2.2.5, p. 42. Available at http://www.acpo.police.uk/documents/crime/2006/2006CBAMIM.pdf.
[37] ACPO, Murder Investigation Manual, 2006, Section 2.2.5, p. 42.
[38] For example, tablets to enable legible recording of notes, easy updating, and exchange of information on a confidential central database.

investigation. All notes should be in a format that allows other IPCC staff to reference them easily.

When the IPCC first arrived at Brixton Police Station on 21 August 2008, the DPS had undertaken to appoint a Crime Scene Manager; the IPCC does not have the resources to appoint their own Crime Scene Managers and it is established practice to rely on the police for this function. There was apparently an initial briefing[39] with the police superintendent at the station about both the events leading to the death of Mr Rigg and the actions taken to secure evidence: the van had been locked, the handcuffs seized and sealed, evidence at the hospital was being monitored, and council CCTV covering the streets from Brixton Hill to Atkins Road requested. The notes indicate that the CCTV in the custody area was still running and for the arrest scene there was a notation "Weir Estate - not covered".[40]

Securing the scene

Two of the most important scenes were not secured: the scene of Mr Rigg's arrest, even though it was noted that there was no CCTV covering that area, and the custody area at the station, as CCTV was still operating. The latter included the holding area (referred to as the 'cage') in the passage leading from the police yard to the custody corridor. The IPCC identified, from an early stage, that the issues of restraint and use of force were significant: handwritten comments at 22.25 hours on 21 August by the senior IPCC investigator on call highlighted these two issues along with "community impact".[41] In light of the fact that the scene of the arrest and initial restraint of Mr Rigg was not covered by CCTV, it was all the more important to consider carefully ways of securing that scene.

The scene of the apprehension and restraint of Mr Rigg is in a roughly square grassed area surrounded by four apartment buildings on the Weir Estate. A paved path runs around the outer edge of the grass, which is enclosed by 0.9 metre high fencing made of metal loops. People can gain access to the buildings by walking around the grassed area on the paved paths, without having to climb over the fence and cross the grass.[42] The metal fencing could have served as a basis for cordoning off the grassy area. This area was not secured on the grounds that it was a busy residential area and members of the public would have walked through, contaminating any evidence after Mr Rigg's arrest and transfer.[43] In order to contaminate the area, people would have first had to climb over the fence, which is approximately hip/waist high for most adults. The IPCC investigation report raises only tentative criticism[44] of this misleading information from the police.

[39] Handwritten notes of the first IPCC investigator to arrive at Brixton police station.
[40] Notes of the senior on-call IPCC investigator.
[41] Handwritten notes of the first IPCC investigator to arrive at Brixton police station.
[42] At the inquest, a witness (Ms Leach) confirmed that the fence literally fenced in the grassed area and ran along the entire grassed area with no breaks. Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 22 July 2012, transcript pp. 70-71.
[43] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para.506. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[44] IPCC, IPCC investigation report Sean Rigg, paras 520-524.

The Review notes that in her internal review of the IPCC investigation DSI Holden concluded that the arrest scene "could have been preserved".[45] **The Review agrees with this assessment and considers that the scene of arrest and restraint should have been preserved and that this should have been reflected more clearly in the IPCC investigation report.**

The internal review report also pointed out that it was not clear that any forensic evidence at the arrest scene would have impinged on the case. The IPCC investigation report noted DI Messenger's argument that little or even no forensic evidence at the arrest scene had been lost by his decision not to secure it, but then stated, "Having said this, the scene was not secured and therefore this can never be known for sure."[46] Like many of the issues raised in the IPCC investigation report, the implied criticism does not materialise; in this instance the report continues "DI Messenger made his decision in good faith and should not attract any criticism for it."[47] The IPCC report is also diplomatic in its final remarks on this issue: "The police have a responsibility to secure and preserve any potential evidence following a critical incident ... it does appear that little consideration was given to the evidential opportunities that may have existed at the site of the arrest."[48]

The Review considers that best practice required securing the scene and that the police were open to criticism for not following best practice. This problem is symptomatic of the difficulties facing the IPCC at the outset of an investigation into a death in police custody. In practice, there are limitations on the IPCC's capacity to control the crucial initial events in the investigation effectively. The IPCC is not present at the very start and must rely on the police, who are on the spot and whose full cooperation they have a right to expect.

Securing CAD and CCTV evidence

The CAD information and CCTV from the police station were included in the list of evidence secured in the first instance by the DPS. This was material evidence concerning the circumstances and events leading up to the death of Mr Rigg. Thus, ensuring that the evidence was complete and secured was a vital first step. However, not all the CCTV cameras in the custody area at Brixton Police Station were working on 21 August 2008: one had not been functioning since May 2008. Later, the Rigg family raised concerns about possible tampering with the CCTV footage by the police at Brixton Police Station.

During the course of its investigation, the IPCC commissioned a report about the CCTV evidence by an expert who found there to have been no tampering with the CCTV footage, although some anomalies relating to the CCTV time readings were noted.[49] The IPCC expert chosen was a former police officer, and this choice was criticised by the Rigg family. The Review has no basis for commenting upon the independence of this individual expert, but must emphasise how important it is for the IPCC to be independent and *to be seen* to be independent; the perception of independence

[45] IPCC internal review of Rigg investigation 20 April 2009, IPCC document D344.
[46] IPCC investigation report, para. 521.
[47] IPCC investigation report, para. 522.
[48] IPCC investigation report, paras 523-524.
[49] Expert statement to IPCC, dated 12 January 2009, IPCC statement S34A.

is an important factor in public confidence in the work of the IPCC. **For the future, this should be borne in mind when choosing *external* experts.**

The IPCC investigation report referred, in its discussion of the CCTV evidence, to the fact that part of Brixton Police Station – the holding area from the outside and parts of the rear yard – were not covered by CCTV, and that maintenance and repair arrangements were problematic.[50] An external CCTV camera covering the holding area was no longer in place on 21 August 2008.[51] Camera 18 was not recording on 21 August and Camera 3 was giving a very poor picture.[52] Given that the area was important, checking the functioning of the CCTV should have been a priority. The Review notes that apparently none of the Brixton police drew this problem to the attention of the IPCC, although some of the equipment had reportedly been listed for repair since May 2008. Whereas police officers operating from the police station might not have been aware of this, senior officers, including the custody sergeants, might be expected to know whether the CCTV monitoring of the area(s) for which they were responsible was working.

An important contribution of the IPCC report was the recommendation regarding improving the system of checks on all police CCTV. The Review notes that the system in Brixton Police Station was not repaired for some time after Mr Rigg's death,[53] but understands that progress has since been made in practice to comply with the IPCC recommendation. **Effective monitoring of custody is an important safeguard for both the police and for the public: CCTV contributes significantly to protection. There is an obligation to maintain CCTV systems in proper working order; the Review considers that failure to do so without reasonable cause may amount to a breach of management obligation.**

Securing the evidence from the four police officers present at arrest

It must have been obvious from the outset of the investigation that a significant part of the evidence would be provided by the four arresting police officers. This evidence needed to be secured. PS Dunn stated to the IPCC in January 2009 that, on the evening of Mr Rigg's death, he took the four officers who had been immediately involved into an upstairs office and arranged for an independent officer to remain with them: "My purpose for doing this was for the welfare of the officers and to ensure that there could be no accusations of the officers 'getting their stories together' and colluding."[54] PS Dunn did not know who had sat with the arresting officers during the evening, but DC Musselwhite stated that they were asked not to discuss the incident.[55]

[50] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 723 ff. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[51] David Thorne, expert report to IPCC, dated 25 March 2009, IPCC report R9L. Mr Thorne notes that the building on which the camera used to be located had been demolished and the camera removed. IPCC investigation report, para. 683.
[52] IPCC investigation report, para. 690.
[53] Expert report to IPCC, IPCC report R9L. Mr Thorne notes that on 2 March 2009 Cameras 18 and 3 were "still not working properly".
[54] IPCC statement S69. This evidence was confirmed at the Coroner's Inquest: Inquisition at Southwark Coroner's Court, 11 June-1 August 2012, 19 July, transcript pp. 194-195.
[55] IPCC statement S84.

According to both sets of handwritten notes made by members of the IPCC on-call team, the arresting officers "were separate" prior to the arrival of the Independent Custody Visitors (ICV) before 00.15 hours on 22 August, but the Police Federation (PF) representatives "put them all in [a] room together"; moreover, according to these notes the "arresting team - were separate - now together after seeing FME [Forensic Medical Examiner] - Federation Representatives." At 02.30 hours the DPS and IPCC had a joint meeting with the four officers, together with their PF representatives and legal representatives.[56]

From the scant notes it is clear that the officers were together for more than an hour before the IPCC and others met with them. It is of considerable concern that the IPCC notes merely present these events as happening; this reveals that the IPCC was not in control of events by this point and did not take steps to ensure that the officers were separated throughout, although a member of the IPCC on-call team appears to have been on the spot while the police officers were still separate.

The IPCC investigation report makes no reference to the joint meeting at 02.30 hours: it only emerged at the Coroner's Inquest. The Review notes that the IPCC documentation does not contain a full record of the joint meeting. **In the interests of an effective investigation, the arresting police officers should have been separated and instructed not to speak, or otherwise communicate with each other about the events, until the IPCC had been able to take detailed initial statements from each. The Review recommends this as standard practice in cases of death in police custody following arrest and detention. Such a safeguard would not preclude any necessary support being provided to each officer individually by appropriate other people.**

The reasons presented by the IPCC for the joint meeting at 02.30 hours were that, because the decision as to the mode of investigation was not made until 08.00 hours on 22 August, the IPCC team were present as observers at the joint meeting, which stemmed from the decision of the police superintendent in charge of operations that night at Brixton Police Station to allow the arresting officers five days operational leave immediately. As a result of this, "it was agreed with the officers' Police Federation representatives and their legal representatives that three officers would provide statements of first account." The DPS and IPCC then met with the police officers and "explained the investigative process that would follow."[57]

This explanation is not convincing and raises serious concerns. The Review considers that the police officers could and should have been kept separate (and provided with the necessary support), until the IPCC had decided on the mode of investigation (the decision that this should be an independent investigation was conveyed on 22 August 2008 by email to the Commissioner in charge of the investigation from the Commissioner leading on community relations issues).[58] Given the nature of the case of Sean Rigg – the death in police custody in Brixton, after arrest and restraint, of a 40 year old black man suffering from mental illness – an independent investigation must have been virtually a foregone conclusion; moreover, there was every reason for immediate action, in particular to

[56] The handwritten notes of one of the IPCC on-call team include the following reference: "0.15hours – ICV – no issues". The typed assessment report dated 22 August 2008 states that the Head of Lambeth ICV visited the holding 'cage' and custody suite and "asserted that she was content with what she had seen". Assessment report, 22 August 2008, IPCC report R3, para. 22.
[57] According to the assessment report by the IPCC on-call team dated 22 August 2008, para. 24.
[58] IPCC document D43.

ensure that the police officers (i) were separated, (ii) gave separate accounts of the events leading up to the death of Mr Rigg, and (iii) were thus protected from any possible allegations of collusion.

The legislative provisions for IPCC discretion in deciding both whether or not to investigate and the mode of investigation[59] do not preclude a presumption in favour of the independent investigation mode in all cases of a death in custody involving restraint. The Review notes that the legislation allows for on-going reassessment of the mode of investigation,[60] ensuring that a preliminary decision in favour of an independent investigation could subsequently have been amended, if necessary. The IPCC statutory guidance has recently been revised, but the provisions, while they do not appear to preclude this option, do not specifically address it.[61]

The Review considers that the IPCC should have been in a position to assume control forthwith: that the on-call team did not feel able to do so may have more to do with IPCC relations with the police and customary practice than with the legislative framework. Whether the investigation was to be independent or managed, the IPCC should still have retained overall control. The Review understands that today an IPCC investigation into a death in custody would always be an independent investigation. The Review recommends that this change since 2008 be formally and unequivocally included in IPCC guidance.

Initial statements taken

The IPCC investigation report states[62] that three of the four officers provided initial statements. The records give a confused account. According to the notes made by one of the IPCC on-call team, it was agreed that two officers (PC Birks and PC Forward) would "provide initial statements this evening (immediate)."[63] The notes indicate that, on the night of 21/22 August, the DPS asked the police officers to provide short witness statements outlining the arrest, transportation, and detention of Mr Rigg at the police station, and also informed them that they were not under investigation but were considered witnesses.[64] The DPS provided the IPCC senior investigating officer on the case with word-processed versions of three statements on 1 September 2008.[65] The statement of PC Glasson, which was not included, was potentially very important: of all the police officers attending the arrest scene, he later said most at interview about the question of Mr Rigg's mental health.

At the Coroner's Inquest, PC Glasson's failure both to make notes about his involvement in the events surrounding the death of Mr Rigg, and to give an initial statement, were robustly pursued.[66] He testified that he was advised by the PF and the solicitor representing the police not to make a

[59] Police Reform Act 2002, Schedule 3, paras 5, 14 and 14D. Available at http://www.legislation.gov.uk/ukpga/2002/30/contents.
[60] Police Reform Act 2002, Schedule 3, para. 15.
[61] IPCC, Revised IPCC Statutory Guidance, 2013. Available at http://www.ipcc.gov.uk/en/Pages/statutoryguidance.aspx.
[62] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 589. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[63] Investigator Workbook, IPCC document D10, p. 11.
[64] Statement by PC Birks, 22 August 2008, IPCC statement S5.
[65] IPCC document D59.
[66] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 29 June 2012, transcript pp. 15-24.

statement that night: unlike his three police colleagues on the team, he was also advised not to make an initial statement.[67] The consequence of this was that his IPCC interview in January 2009 was the first time he made any statement (or notes) about the events surrounding Mr Rigg's death in police custody.

In 2008, it appears to have been more common for officers to refuse to give statements immediately following a death in custody than is reportedly the case today. The Review appreciates that progress has been made since 2008 away from the unhealthy culture of closing ranks in the police in the face of investigations into police conduct. **The Review considers that the IPCC has a right to expect all police officers to cooperate in investigations into deaths in custody; the presumption must be (i) that they will make notes as soon as possible of any important matters, without conferring, and (ii) that they will provide initial statements to the IPCC, also without conferring. All individuals, including police officers, have the right not to incriminate themselves; however, the decision to remain silent may be noted and taken into account in any subsequent proceedings. If, on advice, a police officer does not provide an initial statement for the IPCC, this fact should be included in IPCC investigation reports.**

The statements given by PC Harratt and PC Forward on 22 August 2008[68] were less than one page and provided only a brief outline of events, including some detail about Mr Rigg hitting PC Forward twice and the restraining of Mr Rigg. PC Birks provided a two-page statement on 22 August 2008[69] covering (i) the initial call, to which his police van was responding, about a man answering to Mr Rigg's description behaving violently at Angus House, and (ii) the subsequent call (CAD 7776) to Atkins Road, the sighting of Mr Rigg and his eventual apprehension, restraint and transportation to Brixton Police Station. This was the only evidence from the arresting police officers available to the IPCC until the IPCC interviews were conducted during the second half of January 2009.

As regards obtaining evidence from those police officers most closely involved in the events surrounding a death in police custody, there is a clear tension between the due process rights of any person and the duty of a police officer; as agents of the State, police officers share the obligation to protect life and to ensure an effective investigation of any death in police custody. As one former senior police officer put it to the Review, "Any police officer worth his salt will be ready to tell the truth and cooperate with the IPCC." It appears to the review that full cooperation is not always the case. **The Review welcomes the fact that the IPCC has now been granted the statutory power to require officers to attend for interview.[70] The IPCC cannot compel officers to answer questions, but it is clearly the legislative intent that the police should cooperate fully.**

Initial assessment by the IPCC on-call team

The assessment produced by the on-call IPCC investigation team is dated 22 August 2008. It gives an initial view that, at this stage, must have been based largely, if not exclusively, on police

[67] Coroner's Inquest, 29 June 2012, transcript pp. 22-24.
[68] IPCC statement S7.
[69] Statement by PC Birks, 22 August 2008, IPCC statement S5.
[70] Police Complaints and Conduct Act 2012, Section 1. Available at http://www.legislation.gov.uk/ukpga/2012/22/contents/enacted.

accounts: the IPCC had not interviewed other witnesses yet. It contains information on Mr Rigg's injuries, which were not later considered relevant for inclusion in the IPCC investigation report. The assessment, *inter alia,* describes Mr Rigg's behaviour: "he appears to have been violent throughout the journey".[71] This information could only have come from the arresting officers travelling with Mr Rigg in the police van; however, it does not correspond to accounts later given by the arresting officers when they were interviewed. This discrepancy was not highlighted in the IPCC investigation report.

The initial IPCC assessment report contains no discussion of the merits of allowing the arresting officers to be together for more than two hours before meeting the IPCC, nor of the wisdom of the joint meeting. No details are given in the IPCC investigation report about how the initial statements of the arresting officers were taken.

Very soon after the death of Mr Rigg it was apparent, if it had not been from the very outset, that this IPCC investigation would have a high profile. As the Commissioner leading on community relations accurately pointed out in an email the following day, "We were very conscious that the death of a black man suffering from mental health problems in Brixton police station has the highest potential for community impact."[72] **It would therefore be expected that the IPCC would give the highest priority to this case to ensure a fully effective investigation: independent, thorough, comprehensive and expeditious, and open to public scrutiny.**

The first stage of the IPCC investigation: August 2008 through January 2009

It is clear from the IPCC files that careful and useful investigative work did take place. It is also clear that a number of opportunities were missed.

Delays in interviewing the four police officers

The decision about interviewing the arresting officers was complicated by shifting views as to whether the officers should be treated as witnesses, significant witnesses, as persons suspected of misconduct, or as criminal suspects. A decision to treat them as witnesses was initially taken on 26 August by the senior investigator on the grounds that he had "no evidence to treat officers as anything other than witnesses".[73] However, this decision was changed on 28 August on the grounds that the senior investigator had, by then, seen the custody area CCTV and concluded that "If the officers in the cage of the Brixton Police Station Custody Suite were those involved in the arrest, they should have noted the change in the demeanour of SR [Sean Rigg]. The conduct of the officers must be subject to investigation."[74]

[71] IPCC initial assessment report, 22 August 2008, IPCC report R3, para. 14.
[72] Email dated 22 August 2008 from the Commissioner responsible for community relations to the Commissioner in charge of the case and other IPCC colleagues.
[73] Handwritten workbook 1 of IPCC senior investigator, annotated 30519, logged 26 August 2008.
[74] Handwritten workbook of senior investigator, annotated 30523, logged 28 August 2008.

The Review notes that both these decisions were taken without reference to the Commissioner overseeing the investigation. The issue of the status of the officers was reassessed on 2 September, when the senior investigator noted "It is difficult to see how there can be a prima facie case against any officer once the FME [Forensic Medical Examiner] had seen SR [Sean Rigg], advised that an ambulance should be called and continued to see SR." He decided that he needed more information before the status of the officers could be confirmed and took advice from the IPCC legal department about the content of this position. Interestingly, the senior investigator made this note: "I have not reached the stage when I need to send a memo to the Commissioner".[75]

No definitive decision was taken until after 12 November, when a witness alleged common assault on Mr Rigg by one or more officers. This prompted the IPCC to conduct interviews on the criminal allegation: on 16 January the decision was taken that "the parameters for these interviews would be set solely around the allegation of assault."[76] The allegations concerned the time when Mr Rigg was being conducted to the van by the four police officers and placed in the van (i.e. the period after he had been chased, apprehended, arrested on three charges, and restrained).

During the interviews, the PF representative complained when the IPCC interviewer tried to gain fuller information about the events leading up to the period of the alleged assault (i.e. the arrest and restraint of Mr Rigg). The IPCC interviews in January therefore did not contain full details of the police officers' accounts of what happened when they arrested and restrained Mr Rigg. It was not until late March 2009 that more detailed IPCC interviews, covering a wider range of events and issues surrounding Mr Rigg's death, took place with the four officers; these second interviews were conducted after the Crown Prosecution Service (CPS) gave verbal advice on 12 February 2009[77] not to prosecute any of the officers for common assault (see *Referral to the CPS*).

It is difficult to understand the lack of urgency accorded by the IPCC investigation to interviewing the arresting police officers. On 15 September 2008, the solicitors of the Rigg family wrote to the IPCC requesting that the IPCC take formal statements under caution from the four officers.[78] The argument presented in the IPCC report about waiting in order to avoid having to do more than one interview does not hold as the police officers were eventually interviewed twice: in the second half of January and in late March 2009. However, the March interviews were the first full interviews covering arrest and restraint. By this time months had passed and the officers could legitimately argue that their memories were affected. As the solicitors of the Rigg family stated in their letter of 15 September 2008, "it is vital to get as much accurate information as possible whilst it is relatively fresh in the officers' minds. Sean's family would appreciate your reviewing the evidence at the earliest opportunity."[79]

The Review considers the delay in interviewing the officers unwarranted and indicative of a lack of strategic management by senior IPCC staff. **The Review recommends that it be standard practice**

[75] Handwritten workbook of senior investigator, annotated 30523, logged 2 September 2008.
[76] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 607. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[77] This verbal advice was referred to in the later written advice dated 6 April 2009. CPS rationale for recommending NFA [no further action] against arresting officers, IPCC document D340.
[78] IPCC document D95.
[79] Letter from Hickman & Rose, the Rigg family's solicitors, to IPCC, dated 15 September 2008, IPCC document D95.

in cases of death in police custody for interviews with key police officers to be carried out as soon as reasonably practicable.

There were other lengthy delays in the taking of statements. The internal IPCC review comments that "the reasons for this are unclear." For example, the IPCC instruction to take a statement from PC Owen (who had been asked by the custody sergeant to stand in the holding area with the two less experienced arresting police officers) was postponed until 16 September 2008 and the statement was only taken on 12 February 2009.[80] PC Owen was a potentially important witness, having been present almost from Mr Rigg's arrival in the holding area of Brixton Police Station until he was taken to hospital by ambulance; he assisted in Mr Rigg's treatment by carrying out chest compressions during CPR. In his statement to the IPCC, PC Owen said that he was "advised at the time that I was not to make notes in relation to the incident and that any statement I was asked to make in the future should be my first instance notes."[81] **The review finds this advice inexplicable.** His February 2009 statement for the IPCC represents PC Owen's first instance notes after a period of almost six months. **The matter was not pursued by the IPCC.**

Referral to the CPS

The IPCC made one referral to the CPS in February 2009. This concerned allegations that the police assaulted Mr Rigg while he was being taken to, and placed inside, the police van. Witness C, a resident of the Weir Estate, alleged that one of the police officers taking Mr Rigg to the police van hit Mr Rigg several times on the head with Mr Rigg's white plimsolls and that the four officers, holding Mr Rigg like a battering ram, threw him into the van.

According to the police officers' accounts, when searching Mr Rigg the police removed his trainers because there was a piece of metal found in them. This was later identified as a piece of small metal ruler measuring 10cm x 2cm.[82] The police officers all denied that the assault took place. Another witness living on the Weir Estate called into question the reliability of the first witness; this, and the fact that witness C's Police National Computer (PNC) records included instances of lying to the police, served to discredit the allegations of assault. There were other witnesses at the Weir Estate: three members of a family of local residents stated that they saw parts of the arrest and restraint of Mr Rigg. One could not remember how the police officers had put Mr Rigg into the police van, but did "not recall the man struggling or the police using force."[83] This was confirmed, in essence, by the witness's two relatives.[84]

The Review notes that the two post-mortem examinations of Mr Rigg concluded that there was no evidence of injury indicative of assault and that the bruises and grazes observed were "not unusual in the circumstances in which he was detained."[85]

[80] IPCC statement S93.
[81] IPCC statement S93.
[82] IPCC document D370.
[83] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 149. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[84] IPCC investigation report Sean Rigg, paras 152 and 154.
[85] Post-mortem report and opinion provided on the request of the family's solicitors, IPCC document D369, p. 8.

It is noteworthy that the CPS referred to the police accounts provided by the IPCC as "rather inadequate and lacking in detail".[86] This is hardly surprising since the first interviews with the police officers were brief: PC Birks' first interview lasted 12 minutes, PC Forward's 29 minutes, PC Harratt's 34 minutes, and PC Glasson's 38 minutes. Transcripts were not made at that time (see *Delay in transcribing the interviews*) and the CPS was only provided with summaries of the interviews. The written CPS advice not to prosecute describes the police officers' statements as follows: "they are all rather scant in their accounts and they do not seem to address the points raised by the witnesses."[87]

The CPS advice not to prosecute was based on the "serious conflict of evidence" between the statement by the witness alleging assault of Mr Rigg by the police and the statement of another witness.[88] As is still the case in 2013, the CPS would have applied the test of whether there were a realistic chance of conviction and whether a prosecution would be in the public interest.[89] **It is a matter of concern that the information provided by the IPCC, on which this CPS advice was based, was lacking in detail, deriving primarily from initial outline statements by only three of the four arresting officers in addition to summaries of the four short January interviews, which were primarily limited to the criminal allegations**. **There was no other IPCC referral to the CPS.**

Interim IPCC report

The IPCC interim report was written immediately after the first interviews with the police officers in January 2009. It was seriously affected by the fact that it was written before fuller interviews with the four police officers had been carried out. It should have been clear from the start that detailed interviews with the arresting police officers were central to the investigation.

At the end of January, following internal discussions within the IPCC, it was agreed that there would be a change of senior investigator. This decision followed a lengthy meeting on 14 January 2009, lasting from 16.30 until 23.40 hours, between the Commissioner, the senior investigator, other members of the IPCC team, and the Rigg family and their solicitors. At this meeting the Rigg family raised many points and suggested additional avenues of investigation, but it would appear that not all of these were pursued.

The final IPCC investigation report

The draft of the IPCC investigation report was sent to the Commissioner in charge of the case in late December 2009; the final report was sent to the Coroner and all interested parties on 8 February 2010. The final IPCC investigation report suffers from being a reconstruction of the investigation after the senior investigator, and other key members of the original team, had left the IPCC. Not

[86] CPS rationale for recommending NFA [no further action] against arresting officers, IPCC document D340.
[87] CPS rationale for recommending NFA against arresting officers, IPCC document D340.
[88] CPS rationale for recommending NFA against arresting officers, IPCC document D340.
[89] At the time, the applicable code was the 2004 version. Code for Crown Prosecutors, CPS, 2004 (revised 2012), Sections 4-6. Available at http://www.cps.gov.uk/publications/code_for_crown_prosecutors/ (2012 version).

surprisingly, it reflects the errors made early in the investigation, during the 'Golden Hour', and in the initial stage of the investigation from August 2008 through January 2009.

In addition, the final investigation report did not fully address all the points raised in the January 2009 meeting involving the Rigg family, the Commissioner, and the original senior investigator. It would be expected that, after this lengthy discussion, the Commissioner and senior management would have paid particular attention to ensuring that the main issues arising from this meeting were addressed and conclusions reviewed accordingly.

The final report has structural problems reflecting the approach used at the time. It is, in essence, a narrative investigation report drawn primarily from the accounts given by the four police officers present during the important events: arrest, restraint, transportation, holding in the custody area of Brixton Police Station, and Mr Rigg's collapse. Formal complaints made by the Rigg family and by the manager of the hostel where Mr Rigg was living at the time are also addressed in the report, including through a detailed examination of the CAD calls and the CCTV system at Brixton Police Station. **What is missing is a sufficiently critical analysis of the information presented.**

A report from the IPCC must be expected to raise questions to be addressed by others, such as the Coroner, and to draw robust conclusions not only as to whether misconduct or criminal behaviour occurred, but also as to whether there was poor practice or major omissions in the duty of care constituting at least poor practice and possibly amounting to a breach of the duty of care.

The conclusions in the IPCC report do not address the concerns indicated or implied in the narrative. This reflects a lack of senior management input to ensure analytical rigour. It is for the Commissioner to sign off on the report and therefore it is the Commissioner who is ultimately responsible for the conclusions and, indeed, for the report. The Commissioner should have asked the relevant IPCC senior manager (i) for further investigation on key points, and (ii) a set of more robust findings and conclusions, indicating the major concerns to be addressed by the Coroner, including failures in the duty of care by the Forensic Community Mental Health Team (FCMHT) and the police, as well as the need for improved police training and standards for recognising and responding to people with mental health problems.

The legislative intent is clear: as the guarantor of the independence of the IPCC, the Commissioner must ensure that the IPCC adequately addresses public concerns. **The Review believes that this requires a much more 'hands on' approach from Commissioners than was the norm in 2008.** When a death in police custody occurs, the public needs to understand what went wrong and how similar events could be avoided in future. In an investigation into a death in custody, the Commissioner, senior management and investigators need to work together with a clearly agreed strategic approach, including robust analysis, at key stages, of the emerging evidence. On such a basis, far more robust conclusions could have been developed in the report. For example, the report could have concluded that, if the arresting officers were found to be complying with police standards and guidance applicable at the time, the police standards and guidance were inadequate. **Recommendations should have been made about improvements to police policy and practice.**

The Review welcomes the development of new guidance (agreed in February 2013) on the Commissioner Role in Independent Investigations.[90] The new guidance provides for an updated IPCC delegation scheme and specific arrangements in all critical incidents, including the establishment of a Critical Incident Management Team (CIMT). It is clear that the death of Sean Rigg would have qualified as a critical incident meriting the establishment of a CIMT.

The Coroner's Inquest

In his summation, the Coroner ruled that it would not be safe for the jury to find that Sean Rigg had been unlawfully killed on the basis of the evidence cited;[91] he also ruled out a verdict of neglect by South London and Maudsley (SLaM) NHS Foundation Trust [92] and/or neglect by the MPS.[93] The Coroner accepted that the test to be applied by the jury should concern any action or omission causing death[94] in the sense of more than minimally or negligibly or trivially contributing to the death.[95]

There is a curious mismatch between the bland findings of the IPCC final report that the police complied with good practice and the implications of the report's narrative: although not clearly articulated, this implied that the community health services and the police failed Mr Rigg in a number of ways. It is hardly surprising that when the IPCC investigation report was published on 15 August 2012 – two weeks after the jury's narrative verdict was given on 1 August 2012 at the Coroner's Inquest – the two appeared strikingly divergent.

The jury found, *inter alia*, a series of failures in the care provided to Mr Rigg by the clinical team at SLaM and/or the hostel. They also found a series of inadequacies in communications, assessment and crisis planning. As regards the police, the jury found a lack of sufficient and effective communication within the police, an unsuitable level of force used during restraint, a lack of leadership leading to failure to take effective control of the arrest and restraint situation, and an unnecessary length of restraint in the prone position. The majority view of the jury was that the length of restraint in the prone position more than minimally contributed to Mr Rigg's death. The jury's narrative verdict also identified a failure by the police to identify him as a vulnerable person at the point of arrest, a lack of care while he was inside the van at the police station, a lack of assessment of his physical and mental condition by the police, a failure to follow the standard operating procedure relating to mental health, and unnecessary and inappropriate retention of restraint. The jury found that an absence of appropriate care and urgency of response by the police when he was in the 'cage' of the police station more than minimally contributed to death.

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[90] IPCC, Commissioner role in independent investigations, February 2013. Available at http://www.ipcc.gov.uk/Commission documents/Item 14 - Commissioner Role in Independent Investigations [NPM].PDF.
[91] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 27 July 2012, transcript p. 4.
[92] Coroner's Inquest, 27 July 2012, transcript p. 6.
[93] Based on the assessment that one of the essential ingredients was missing, namely a direct and clear causal connection between the failures by the police and Mr Rigg's death. Coroner's Inquest, 27 July 2012 transcript, pp. 7-14.
[94] Coroner's Inquest, 27 July 2012, transcript p. 2.
[95] *Regina v. HM Coroner for Inner London South District, ex parte Douglas-Williams* ([1998] EWCA Civ 101 [1999]) 1 All ER 344.

In November 2012, the Coroner sent Rule 43 letters to SLaM NHS Foundation Trust and the MPS stressing that, four year after Mr Rigg's death, there was still "a lack of clarity and incomplete understandings of the roles of different organisations and when they should communicate and act together – especially in an emergency". The Coroner noted gaps in "knowledge, awareness, teamwork, joint working and policing."[96]

The Coroner's concern that systemic shortcomings could lead to a recurrence of deaths in custody arose in relation to the failure by SLaM to conduct an urgent Mental Health Act (MHA) assessment following signs that Mr Rigg was relapsing.

Concerning the police response to Mr Rigg, the Coroner referred to clear inadequacies in mental health training for both MPS call handlers and police officers. The Coroner also called for a review of the MPS's information and training with respect to the mental and physical health needs of mentally ill prisoners, including a review of whether training and information was being passed to all members of the MPS.The Coroner highlighted as concerns

- the lack of proper understanding of the powers available in the event of a mental health relapse.
- the timeliness of MHA assessments of a person who may be relapsing.
- the joint protocols between SLaM, London Borough of Lambeth (LBL) and MPS for meeting the needs of those presenting with urgent psychiatric problems that require interagency co-operation.
- the need for greater emphasis on improving mental health procedures, training, the role of leadership, and decision-making in restraint situations.

The responses to the Rule 43 letters indicate that the authorities have taken steps to address some, if not all, of the issues raised. The Review notes (i) the considerable efforts by SLaM to address issues raised by the case of Mr Rigg, and (ii) the subsequent actions and improvements, examples of which are to be found in the report on the Inquest and the report on the SLaM review carried out by Mark Rapley.[97]

The MPS has also taken steps forwards in terms of clarifying policy: the guidance on safer detention and handling of persons in police custody has been revised,[98] and practical measures, such as piloting CCTV in police vans, are also underway. It remains to be seen whether lessons have been in learnt in practice in terms of fulfilling the duty of care to persons with mental health issues. The Review is aware of subsequent deaths in police custody that raise issues similar to those arising in the case of Mr Rigg.[99]

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[96] Rule 43 letter with recommendations arising from Lambeth Safeguarding Adult Partnership Board Learning and Action Plan, LSAPB, London, 2013.

[97] SLaM NHS Foundation Trust, Report to Lambeth Overview and Scrutiny Committee on Inquest into death of Sean Rigg, 23 Oct 2012. Available at http://www.lambeth.gov.uk/moderngov/documents/s50147/02b%20Sean%20Rigg%20Inquest.pdf.

[98] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (second edition), 2012. Available at http://www homeoffice.gov.uk/publications/police/operational-policing/safer-detention-guidance?view=Binary.

[99] For example, the case of Anthony Davies, who died in April 2011 from acute alcohol poisoning while being transported in the cage of a police van, which raised issues around identifying the need for medical care. See also the case of Jacob Michael, who died in August 2011 in police custody, which raised issues about the need for medical

III. Issues for the IPCC investigation

The Review considers that an IPCC independent investigation into a death in police custody has both the power and the duty to examine all the relevant factors, even those occurring before police contact; in the case of Mr Rigg, for example, it should have encompassed the provision of mental health care prior to his death, "even if that meant that it had to investigate events which occurred before the man had come into contact with the police."[100]

The reader of the IPCC investigation report is provided with considerable detail concerning the events leading up to Mr Rigg's apprehension (in the section entitled Background), including much interesting contextual information. However, some key points are missing or left unresolved; when the findings and recommendations are presented, the reader is left with many unanswered questions. It should have been the role of senior IPCC management to ensure that these were addressed in the report's conclusions and/or raised as concerns for the Coroner's Inquest. The Review seeks to explore some of the most important issues implied in the IPCC report's narrative that were neither highlighted for further exploration nor included among the findings and recommendations of the report. The Review also addresses some of the missed opportunities for an appropriate response to Mr Rigg's unfolding situation that might have averted the tragedy of his death.

A. Community mental health care[101]

A reading of the carefully described chronology of events leading up to Mr Rigg's departure from the hostel in Fairmount Road reveals that several opportunities were missed for action in response to Mr Rigg's deteriorating mental health. The report leaves the impression that the IPCC did not feel in a position to draw conclusions about these issues. Unlike the Review, the IPCC team did not have the benefit of advice from a mental health expert; however, "almost half of those who died in, or shortly after leaving, police custody in 2011-2012 were identified as having mental health problems".[102]

An IPCC investigation into the death of a person known to have suffered from a mental health illness should, at a minimum, pose critical questions and raise the key issues relating to the circumstances of the community mental health care of the person prior to his or her death. At the time of his death, Mr Rigg had a considerable history of contact with mental health services and the

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attention for a person transported under restraint by the police after the use of pepper spray, and the case of James Herbert, a young man with mental health problems whose death in June 2010 occurred after he was detained under the Mental Health Act and held naked in a police cell.

[100] *R (on the application of Reynolds) v. Independent Police Complaints Commission* [2008] EWCA Civ 1160 [2009] PTSR 1229: the court found that the IPCC has a power and a duty to independently investigate, "even if that meant that it had to investigate events which occurred before the man had come into contact with the police."

[101] This section was informed by Martin Corfe's 2013 report on the mental health and forensic history of Sean Rigg for the Review.

[102] IPCC, Commissioner's Foreword: IPCC investigation report Sean Rigg, 15 August 2012. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx. Quoted in Home Affairs Committee, Eleventh report: IPCC, 29 January 2013, 'Key Facts'. Available at http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/49402.htm.

police. His offending behaviour was associated with his mental illness and included markers for mental health, violence (e.g. assaulting the police), and weapons.

Short psychiatric and forensic history[103]

At the time of his death, Mr Rigg was diagnosed with the severe and enduring mental illness paranoid schizophrenia. When well, he was described as likeable and a talented musician. When his mental health deteriorated, his behaviour was reportedly difficult to manage and he could present a risk to himself and others. Therefore, he warranted a high level of supervision in the community.

His mental health became a problem, according to family members, in the late 1980s. In 1988, while admitted to hospital under Section 2 of the 1983 Mental Health Act (MHA), he was given a diagnosis of drug-induced psychosis.[104] During subsequent admissions, he was given a diagnosis of paranoid schizophrenia. Mr Rigg was admitted about thirteen times under the civil and forensic parts of the MHA, including under Section 136 and, in 1988, under Section 37/41 of the MHA (i.e. under a hospital order with restrictions). This followed a serious assault on a victim known to him.

His offending came to notice in 1995, after he was diagnosed with serious mental health problems. Mr Rigg had presented with problems in his conduct within the community prior to this. Prior to the hospital order being made in 1988, the police had used holding powers, including Section 136 of the MHA, in relation to his conduct: on one occasion, his delusional views became fixated on two women who were unknown to him and who had to seek refuge in a shop.

In 2004, a mental health tribunal gave Mr Rigg an absolute discharge from the restriction order. At the time, his care team from SLaM supported his application for the order to be lifted. Within a short space of time, problems with poor compliance regarding depot and oral medication occurred and there was a relapse in his mental illness.

While unwell in 2004, Mr Rigg travelled abroad but required repatriation on more than one occasion, following arrest in one instance and detention in a psychiatric facility in another. This resulted in the cancellation of his passport.

Around this time, he became a clear risk to himself and others. His conduct included assaults, culminating in an assault on a police officer in 2006: he was found to have a small hammer, which he said was to kill the police officer.

His delusional beliefs fuelled offending behaviours, which could be focused on family members, people known to him, authority figures, and, on occasion, strangers. At this time, SLaM felt that he was not suitable for referral to the local Multi-Agency Public Protection Arrangements (MAPPA) team or consideration for a further hospital order or community treatment order. There appeared to be a desire to avoid assertive follow-up with him, partly because of his strong views about the

[103] As a basis for this short history, the Review used the detailed report prepared for the purpose by Martin Corfe. Martin Corfe, Report on mental health and forensic history of Sean Rigg for the IPCC external independent review, 2013.
[104] It is usual to avoid making a diagnosis of a severe and enduring mental illness when other factors, such as drug use, are present. It was noted that he had used cannabis since the age of sixteen.

misdiagnosis of black people due to psychiatrists having a poor understanding of cultural differences (a view not uncommon among Afro-Caribbean service-users).[105]

In the period leading up to August 2008, there was lack of both recent, specialised risk assessments and clear relapse planning. In the weeks before his death, Mr Rigg had not been compliant with medication; he had also been isolating himself, not eating, consuming his own urine, and expressing bizarre ideas about the treatment of others in the hostel where he was living. SLaM made an aborted attempt to assess him on 11 August 2008. A decision to use the MHA was not acted on. This meant that there was no change in his care to address his seriously worsening condition. It has been agreed by SLaM that from 11 August 2008 Mr Rigg was in need of acute treatment and that his placement in the community was unsafe.

Risk strategy in the weeks before 21 August 2008

The relationship with the FCMHT was difficult due to concerns about medication. At this time various relapse indicators had been identified in Mr Rigg's care plan, which included paranoia about his son, suspiciousness, threats/acts of aggression, grandiose beliefs, and cannabis and LSD use.[106] The plan indicated a need for a Responsible Medical Officer review and then possible use of the MHA.

In July 2008, Mr Rigg began to decline his medication. Services tried to maintain positive engagement with him, including by continuing to help him gain alternative, less supervised accommodation, despite his lack of insight into his care needs at the time. A clinical review was aborted on 11 August 2008: the IPCC investigation report referred to the failure of the SLaM team to attend the scheduled meeting,[107] which has been accepted by SLaM as a time when he was acutely unwell (as discussed above).

The IPCC investigation report relates the visit by Dr Rogers, with a medical student, to the hostel on 13 August. However, it does not report that Dr Rogers concluded that admission to an acute mental health unit was required and that this was agreed in a telephone discussion with the consultant psychiatrist covering while the head of the FCMHT was on leave. There is also no account of the fact that no plan was started to arrange an assessment under the MHA. Pressure on beds has been cited as a possible reason for no planned admission being undertaken at the time.

The IPCC investigation report documents that Mr Rigg was placed in the 'Red Zone', involving twice-daily communication between the hostel and the FCMHT. At the time, emails from the hostel expressing a high level of concern about the plan indicate that the placement was unsafe.

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[105] Clare Xanthos (2008) 'Racializing mental illness: Understanding African-Caribbean Schizophrenia in the UK', *Critical Social Work*, Vol. 9, No 1. Available at http://www.uwindsor.ca/criticalsocialwork/racializing-mental-illness-understanding-african-caribbean-schizophrenia-in-the-uk.

[106] Medical notes later recorded that he was known to have experimented with LSD on only one occasion in the past.

[107] The IPCC investigation report referred to the Serious Incident Review conducted by the Chief Executive Officer of Penrose Housing following the death of Mr Rigg. IPCC, IPCC investigation report Sean Rigg, 15 August 2012. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

There was an attempt to refer Mr Rigg to the home treatment team on 18 August 2008, but the referral was turned down due to his lack of consent to treatment. Mr Rigg's care coordinator from the FCMHT visited the hostel on 18 August 2008 in relation to other clients as well as Mr Rigg, but decided with hostel staff that it would be unsafe to approach him in his room; this should have evoked a further urgent request for a domiciliary visit.

The Review has simulated an assessment,[108] based on information gleaned from all the sources necessary for the Health of the Nation Outcome Scales (HoNOS) Secure Needs Assessment[109] to be used, to gain a picture of how Mr Rigg might have been viewed in the summer of 2008 if such an assessment had been completed following the 11 August 2008 visit. The security scales are specifically designed for clients involved with forensic services, such as Mr Rigg. He shows a score of 26 out of 48 on scales 1-12, scoring particularly high on the clinical indicators, such as psychosis. He also shows significant scores for risks to others. **If a HoNOS Secure Need Assessment had been completed for Mr Rigg, it is very likely to have (i) indicated a need for prompt action, and (ii) identified community placement at the hostel as unsuited to contain the risk.**

Restriction options

There was a long period of effective follow up with Mr Rigg from 1998 until 2004 with no significant offending. In 2004, Mr Rigg's appeal against the restriction order was supported by clinical services in the hope that this would forge a therapeutic alliance. With hindsight it appears that the period of effective engagement and compliance with medication ended after the restriction order was removed. Offending at a minor level, and the move from depot medication to oral medication, was accompanied by relapses in Mr Rigg's mental health, resulting in a number of mental health crises, which placed him and others at significant risk. The Review notes that restriction orders have been found to reduce re-conviction rates of patients in England and Wales, "with a trend to reduc[ing] reoffending."[110]

The Review considers that the IPCC investigation report might have raised concerns about lack of preventive action in response to the increased level of risk: the conduct presented by Mr Rigg warranted reconsideration of the need for a restriction order following his return to presenting a risk of violent offending.

A Community Treatment Order (CTO) could have been considered for Mr Rigg following one of the relapses that resulted in hospital admission after the restriction order had been removed. Under a CTO, if Mr Rigg did not comply with the conditions for his community placement, the clinician in charge of his care could have recalled him to hospital. If the CTO had been linked to a plan to take

[108] Health of the Nation Outcome Scale/Secure Forensic, assessment completed by Martin Corfe.
[109] Health of the Nation Outcome Scale for Users of Secure and Forensic Services, 'How to use HoNOS-secure' (version 2b), February 2007. Available at http://www.rcpsych.ac.uk/pdf/HoNOS-secure%20v2b%20explanation.pdf.
[110] Baxter, Richard, Sophia Rabe-Hesketh, and Janet Parrott (1999), 'Characteristics, needs and reoffending in a group of patients with schizophrenia formerly treated in medium security', *Journal of Forensic Psychiatry*, Vol. 10, No 1, pp. 69-83. Abstract available at http://www.tandfonline.com/doi/abs/10.1080/09585189908402140.

depot medication, serious relapses might have been averted. The Lambeth Safeguarding Adults Partnership Board's response to the Coroner indicates a need to make more use of CTOs.[111]

The Review considers that, given Mr Rigg's proven relapse problems and specific risks, a CTO was justified. The IPCC investigation could have considered this option and raised it as a concern to be addressed by the Coroner: if a CTO had been made prior to removal of a civil section order, it could have produced effective follow-up and compliance with medication similar to that in place at the time of the restriction order.

Multi-Agency Public Protection Arrangements (MAPPA)

The IPCC investigation report does not comment on the apparent absence of wider inter-agency planning, such as Multi-Agency Public Protection Arrangements (MAPPA). At the Coroner's Inquest, the statement was made that Mr Rigg was below the threshold for MAPPA follow up. Based on current MAPPA guidance,[112] any person subject to a hospital order with restrictions would be seen as requiring planning for MAPPA. In 2008 the guidance was less specific, but Mr Rigg's level of offending could have indicated his suitability for MAPPA due to the potential risk of injury to a known victim. Consultation with the probation service indicates that Mr Rigg's offending would have placed him into MAPPA 2 territory in 2008, and that the probation service would have accepted a review and considered Mr Rigg for MAPPA involvement if SLaM had made a referral. **The Review considers that there is an issue of differences in stakeholders' understanding of MAPPA.**

Had MAPPA been in place at the time of Mr Rigg's relapse, all agencies should have worked jointly to ensure that he was assessed for possible MHA intervention following any instance of public disturbance or other offending. It would appear that practice in the Brixton/Lewisham area does not reflect the current MAPPA guidance. The IPCC investigation report did not explore the lack of MAPPA.

The Review suggests that, in future, IPCC investigations should examine MAPPA activity in all cases of deaths in custody of persons with a mental health condition and offending histories involving risk of harm to others.

The response[113] to the Coroner's Rule 43 letter from Lambeth Safeguarding Adults Partnership Board (LSAPB) cited the Learning and Action Plan; it indicated that the care plans were reviewed in 2011 but might require further review. The plans included steps to improve care-planning activity across SLaM, the police, Penrose Housing and all other agencies. LSAPB also reported sharing of

[111] It also recommended further testing of the effectiveness of CTOs as the evidence base is limited. Rethink Mental Illness, Community Treatment Orders fact sheet, 2011. Available at http://www.rethink.org/search_clicks rm?id=14180&destinationtype=2&instanceid=802722.

[112] Lili Ly and Daniel Howard (2004) Statistics of Mentally Disordered Offenders 2003: England and Wales (Statistical Bulletin 1604). Available at https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=208433 (abstract only). Cited in Jayanth Srinivas, Sarah Denvir, and Martin Humphreys (2006) 'The Home Office Mental Health Unit', *Advances in Psychiatric Treatment*, Vol. 12, pp. 459-461. Available at http://apt rcpsych.org/content/12/6/450 full.pdf+html.

[113] Role matching HM Coroner requests in Rule 43 letter with recommendations arising from Lambeth Safeguarding Adult Partnership Board Learning and Action Plan, LSAPB, London, 2013.

information between the police and SLaM regarding forensic patients. However, it would appear that, currently, the inclusion criteria for MAPPA are not widely or consistently understood by the various stakeholders.[114] **The Review broadly supports the measures referred to by LSAPB, but suggests that further work needs to take place with partners regarding who should be included in the MAPPA process.**

Medication issues

There was a period when Mr Rigg was known not to be taking his medication. As alluded to in the IPCC investigation report,[115] his history of relapse was clearly associated with not taking his medication. Various strategies could have been employed to encourage compliance, such as involving the family to help engage in treatment, as this had worked in the past. Use of assertive outreach principles[116] in follow-up by the FCMHT would have sent a clear message to Mr Rigg. Discussion of potential use of the MHA, if he continued to deteriorate, would have underlined the concerns of both the team and the family. Exploration of independent accommodation could have been shelved pending compliance with the treatment plan. Increased follow-up of Mr Rigg, out of concern for his health in relation to his poor dietary intake and urine drinking, might have prompted a positive response.

In its response to the Coroner's Rule 43 letter, LSAPB identified non-compliance with medication by forensic patients as requiring a higher zoning priority due to the risk to the public.[117] This suggests that improvements have been made since 2008. LSAPB also identified a need for better family liaison work.[118]

Non-compliance with depot medication made it far more difficult to ensure that Mr Rigg remained well. Use of depot medication is seen as significantly reducing the risk of relapse with patients with schizophrenia.[119] LSAPB indicate a need to prioritise patients who decline depot medication but note that SLaM report that about 80% of patients decline medication at some time and that providing all with assertive follow up would be costly. However, the document indicates that a higher level of priority should be given to forensic patients due to the risk to the public. **The Review agrees that specialised and better-staffed forensic services would enable a higher level of community follow up.**

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[114] MAPPA Guidance (version 4), Ministry of Justice, 2012. Available at http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf.

[115] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, paras 29 and 32-33. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

[116] G.R. Bond, J.H. McGrew and D.M. Fekete (1995) 'Assertive outreach for frequent users of psychiatric hospitals: A meta-analysis', J*ournal of Mental Health Administration*, Vol. 22, No 1, pp. 4-16.

[117] Role matching HM Coroner requests in Rule 43 letter with recommendations arising from Lambeth Safeguarding Adult Partnership Board Learning and Action Plan, LSAPB, London, 2013, Recommendation 2.

[118] Role matching HM Coroner requests in Rule 43 letter, Recommendation 4.

[119] C. Leucht, S. Heres, J.M. Kane, W. Kissling, J.M. Davis and S. Leucht (2011) 'Oral versus depot antipsychotic drugs for schizophrenia a critical systematic review and meta-analysis of randomised long-term trials', *Schizophrenia Research*, Vol. 127, Nos 1-3, pp. 83-92. Available at http://www.ncbi nlm nih.gov/pubmed/21257294.

The Review recommends that future IPCC investigation reports give more attention to missed opportunities to provide care before crisis involvement with the police.

Culturally sensitive psychiatric care

Mr Rigg perceived that some of his behaviour was viewed as indicative of mental illness, whereas he saw it as a cultural issue.[120] In their concern not to be seen as stigmatising Mr Rigg, service providers may have conveyed a message that follow up could be fairly relaxed. There is a fine balance between cultural sensitivity and adequate follow up. **Given the proven relapse pattern and specific risk to known individuals, a more assertive follow up stance might have reduced the risk of relapse.**

999 calls from Penrose Hostel

Mr Rigg had been residing voluntarily at the Penrose Hostel in Fairmount Road, Brixton, one mile down Brixton Hill from the Brixton Police station. The hostel caters exclusively for forensic mental health placements: people who have both a mental health condition and a history of contact with the criminal justice system. According to members of the SLaM forensic team who were involved with the community care provision for Mr Rigg, all residents were people who would be expected to present difficult management problems if their mental health condition deteriorated.

When the arresting police officers were interviewed by the IPCC, they stated that they did not know of the hostel. In her first emergency call to the police, Ms Wood (the manager of Penrose Hostel at the time) emphasised that the Central Communications Command (CCC) system of the MPS should have listed the hostel as marked for serious forensic residents: "Our building should be on permanently green alert; we work with schizophrenic clients and when they go they really go; they are a risk to public safety."[121] **There was a clear need for co-ordination between the police and the community mental health services to ensure that the police were aware of the status of the hostel at Fairmount Road. The Review welcomes LSAPB's indication that placement for forensic clients will be reviewed and incorporated into the Police CAD system** (i.e. the Computer Aided Despatch from Call Centre system in which a message is created by an operator when a police response is requested).[122]

The first and subsequent 999 calls could have activated a MAPPA emergency plan, had one been in place. The IPCC investigation report appropriately noted some reluctance on the part of Penrose staff when the police operator asked if the MHA should be used. This was possibly due to a desire to

[120] There is a higher level of diagnosis of severe and enduring mental illness in black men in the UK. Mental Health Foundation Black and minority ethnic communities, n.d. Available at http://www.mentalhealth.org.uk/help-information/mental-health-a-z/B/BME-communities/ [last accessed 11 March 2013].
[121] Transcript of CAD calls from 21 August 2008, IPCC document D185. Ms Wood later explained that "green alert" was her way of saying that the hostel should have been permanently flagged to the police as a mental health facility catering for forensic residents: see IPCC report R13.
[122] Role matching HM Coroner requests in Rule 43 letter with recommendations arising from Lambeth Safeguarding Adult Partnership Board Learning and Action Plan, LSAPB, London, 2013, Recommendation 30.

maintain a therapeutic relationship with Mr Rigg. However, an MHA intervention at this crisis point should not have prevented a therapeutic alliance being re-established once the patient was in the recovery phase. If the practical details of a crisis plan for Mr Rigg had been in place, the police might have been called to the hostel with a view to transferring Mr Rigg to another health facility under Section 136 of the MHA (or another order), where he could have received appropriate medical treatment more promptly.

The Review considers as encouraging the increased involvement of Penrose staff in risk planning and reviewing activities, as detailed in the LSAPB response to the Coroner's Rule 43 letter.

Conclusions

The Commissioner's Foreword to the IPCC investigation report contains the clearest statement up to this point about omissions in community mental health care regarding Mr Rigg's case: "At the Inquest, concerns were raised about the care Mr Rigg received from the South London and Maudsley Mental Health Trust (SLAM). It is clear that, although staff at the supported hostel where he was living recognised that his condition was deteriorating during August and that his medication was overdue, he was not subject to a mental health risk assessment by staff at SLAM."

The Review notes both the considerable efforts by SLaM to address issues raised by the case of Mr Rigg, and also the subsequent action and improvements, examples of which are to be found in the report on the SLaM review carried out by Mark Rapley[123] and the report on the Coroner's Inquest.[124]

Looking forwards, the Review recommends that, in IPCC investigations of deaths in custody involving mental health service users, there is a clear expectation that partner services, health services, probation services, social work services, voluntary sector organisations and others will share information at an early point.

Regarding the possible involvement of a mental health expert in future IPCC investigations, the Review suggests that the IPCC examine

- the potential need through an audit into deaths in custody during 2012 to establish the frequency of cases in which a mental health perspective would been helpful,
- a system of classifying cases to reflect no mental health concerns (MHC), minor MHC, moderate MHC, and high MHC, and
- simulated assessments in some cases (e.g. HoNOS and HoNOS Secure) in order to understand needs in relation to care provision.

With regard to future IPCC investigations with a mental health component, the Review suggests a six month pilot based on (i) initial advice from a mental health professional consulting on an *ad hoc*

[123] Mark Rapley, Learning and Action Plan. Lambeth Adult Safeguarding Adult Partnership Board, December 2012.
[124] SLaM NHS Foundation Trust, Report to Lambeth Overview and Scrutiny Committee on Inquest into death of Sean Rigg, 23 Oct 2012. Available at http://www.lambeth.gov.uk/moderngov/documents/s50147/02b%20Sean%20Rigg%20Inquest.pdf.

basis at the discretion of the Commissioner and senior investigator, (ii) a complex review of inter-agency work, and (iii) recommendations to feed into IPCC investigation reports.

B. The 999 calls

On 22 August 2008, the Commissioner leading on community relations in respect of the case identified as issues forming part of the IPCC investigation (i) mental health, and (ii) the failure to link the calls from the hostel with those from members of the public reporting Mr Rigg's behaviour after he left the hostel.[125]

The IPCC report documents at length the CAD system, which was the subject of complaint by the Rigg family and by the hostel manager; examination of the CAD calls, including the delays in responding to calls and the failure to link calls, forms a substantial part of the IPCC investigation report. The Commissioner's Foreword was robust about the problems found: "On the day Mr Rigg died, it took over three hours for police to respond to calls from the hostel where Mr Rigg was living, when staff reported their concerns that he had ceased taking his medication and was behaving in a way that could pose a risk to himself and others. By the time they arrived, Mr Rigg had left, had been arrested and was already in Brixton police station. Our inquiries established that this delay was not, unfortunately, unusual."

The detailed account of the various 999 calls concerning Mr Rigg on the afternoon/evening of 21 August 2008 provides a timeline in the IPCC investigation report. The IPCC had information from the Mobile Data Terminal (MDT) in the police van that transported the arresting officers and, later, Mr Rigg. The timings of the van's movements are not included in the chronology presented in the IPCC report but are to be found in the IPCC information records. The narrative includes the actions of the police officers and van, as reported in accounts provided by the officers themselves to the IPCC.

The calls are examined in the IPCC investigation report as a distinct issue (corresponding to complaints made later about the calls); this analysis is separate from the larger issue of the overall timeline. The explanations in the IPCC investigation report are clear and detailed about the CCC system, the CAD messages, and the coding system for responding to calls in operation.[126] It is not for the Review to investigate these events again. **The Review considers that the IPCC investigation report correctly identified a series of problems with coordination of emergency calls, the system for responding and deployment, and the absence of oversight to ensure that updated call information on the central system was known to police officers operating in the field; it did not criticise the failure of the police officers to check the information on the system by radio or van MDT.**

As a result of the IPCC's examination of the CAD calls, and its presentation of extracts of the discussion between the callers and the call operators, one of the call operators was

[125] Internal memo from the Commissioner in charge of community relations to the Commissioner in charge of the investigation (copied to various members of the IPCC staff), dated 22 August 2008, IPCC document D43.
[126] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, paras 256-311. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

subsequently subject to an informal management action in respect of the complaint from the hostel manager.

An integrated timeline of events

The IPCC investigation used an analytical chart mapping statements by police officers, hostel staff and witnesses against CAD logs, and also CCTV footage, to gain a better sense of the timeline. Although available in electronic form, the chart was not included on the Home Office Large Major Enquiry System (HOLMES) but remained among the unused material. As the chart has not been located in electronic form and omits some important details, the Review presents a simple table below showing a non-exhaustive integrated timeline reconstructed as far as possible from mechanical sources, including the records of the CAD calls, the information recorded on the MDT in the police van, the photographs on the mobile phone of a local resident, and the CCTV footage from the Penrose Hostel on Fairmount Road, various Brixton streets and Brixton Police Station.

Time	Event	Instigator	Action / Outcome / Content
16.53	CAD 6148	Mr Alvares, Mr Stevens at hostel, Fairmount Road	Advised of signs of a breakdown of a man (name and date of birth given) with mental health issues, threatening behaviour, history of assaulting police, risk to staff and residents Call graded S = response soon
17.05	CAD 6148	CCC Supervisor	Marked as not a police matter Downgraded to R = no deployment at 17.06
17.09	CCC update	CCC call back to hostel	Call for update: Mr Rigg reported in front garden of hostel wearing only underpants and performing martial arts
17.10	CAD 6148	CCC Supervisor	CAD upgraded
17.32	CAD 6549	Mr Stevens from hostel, referring to CAD 6148	Threatening behaviour, throwing things in garden, causing damage to hostel property, severe risk to people at hostel CAD graded S
17.34	CAD 6549	CCC	CAD 6549 linked to CAD 6148
17.35	Request for unit to attend	Brixton Integrated Borough Operations	Attempts to get units to respond to CADs 6148 + 6549 without positive response
17.39	CAD 6148		CAD sent to LD22 police van
17.42	CAD 6148		CAD 6148 returned no answer from LD22

Time	Event	Instigator	Action / Outcome / Content
17.45	CAD 6148		CAD sent to LD23 van
17.48	CAD 6148		CAD returned no answer from LD23 van
17.51	CAD 6148		CAD sent to LD23 van again
17.54	CAD 6148		CAD returned no answer from LD23 van again
17.58	CAD 6148		Another no answer received from LD23 van
18.01	CAD 6148		CAD sent to LD2 van
18.04	CAD 6148		No answer from LD2 van
18.05	CAD 6148		No answer acknowledged; CAD resent to LD23 van
18.08	CAD 6148		No answer returned from LD23 again
18.46	CAD 7311	Mr Stevens, referring to CAD 6148	Mr Rigg was outside, had damaged property, was threatening; CCC asked whether hostel wanted police to come and section; hostel reply was not necessarily to section him, but he was a severe risk to everyone at hostel
18.47	CAD 7311	CCC	CAD 7311 linked to CAD 6148
19.03	CCTV	At hostel	Mr Rigg shown on hostel CCTV outside hostel
19.08.01	CCTV	Street CCTV	Mr Rigg shown on Brixton Hill
19.19	CAD 7678	Ms Wood, hostel manager but not at hostel	Police had not arrived; man was psychotic and in street throwing karate punches (Mr Rigg had left hostel by this time, unbeknownst to Ms Wood)
19.24	LD2N van	MDT in Van	Recorded that van left Brixton Police Station
19.26	LD2N	MDT in van and street CCTV	Van on street CCTV with blue lights and sirens proceeding down Brixton Hill towards Streatham
19.29	CAD 7776	Witness A, member of the public	Reported bare-chested man wearing white trousers attempting to karate kick and chase passer-by
19.29.09	LD2N van	MDT in van	Stopped at Atkins Road; person there told police bare-chested man had moved on
19.30	**CAD 7789**	**Mr Jung, member of the public**	**Reported man threatening and attacking people in the street; "he looks mad"; description – white trousers, bare chest, black/mixed race, 6 ft. Operator: "must have mental health issues"** **Mr Jung: "Could well have"**
19.31	CAD 7789	CCC	Linked CAD 7789 to CAD 7776
19.31.24	LD2N van	MDT in van	Recorded van moving off again

Time	Event	Instigator	Action / Outcome / Content
19.32	CAD 7776		Sent to and acknowledged by LD2 van
19.34	**CAD 7789**	**CCC**	**Recorded on CAD "must have mental health issues"**
19.35.08	LD2N van	MDT in van	Recorded LD2N van deployed to CAD 6010
19.36.26	LD2N van	MDT in van	Recorded LD2N van deployed to CAD 7776
19.36	LD2N van	MDT in van	LD2 time of arrival communicated via MDT by PC Birks
19.37	LD2N van	CADs 7776 + 7789	LD2N van at scene with Mr Jung
19.37.24	LD2N van	MDT in van	LD2N van drew in on Weir Road at junction with Radbourne Road
19.39	**Photo 1**	**Ms Leach**	**Photo on mobile telephone of Mr Rigg prone on the ground, being restrained by 4 police officers**
19.39	CAD 7776		213LX: male now detained; details added by Akinyele
19.40	CAD 7678	CCC	CAD 7678 linked to CAD 6148
19.42.28	LD2N van	MDT in van	Van moved from first parked position around and eventually into the Weir Estate
19.43	**Photo 2**	**Ms Leach from her flat**	**Photo on mobile telephone of Mr Rigg still prone on ground, hands cuffed in stack position, 3 police officers present, 2 restraining**
19.45.39	LD2N van	MDT in van	Van stationery at new position on Belthorn Crescent on the Weir Estate
19.48	CAD 7776		271LX (PC Birks' call sign) reported in that a male was detained for public order by arresting officers
19.49.23	LD2N van	MDT in van	Van set off back to Brixton Police Station
19.52	CAD 8062	Ms Wood	Mr Rigg a threat to the public (she was unaware that Mr Rigg had been apprehended by the police by that time)
19.53	CAD 8062	CCC	CAD 8062 linked to CAD 6148
19.55.23	LD2N van	MDT in van	Arrived back at Brixton Police Station
20.00	L3N van		Another police van deployed to hostel, arriving 20.12
20.03	LD2N van in police station yard	CCTV in yard	Mr Rigg moved from parked van into the caged holding area of custody corridor

Time	Event	Instigator	Action / Outcome / Content
20.06	PS White	CCTV	Custody Sergeant's first visit to Mr Rigg
20.10	Police officers	CCTV in 'cage'	Officers in the 'cage' holding area shown trying to stand Mr Rigg up
20.11	Mr Rigg's collapse	CCTV	Brixton Police Station custody corridor CCTV shows Mr Rigg collapsed and slumped to the floor
20.13.10	FME	CCTV	FME shown arriving, bends over Mr Rigg and leaves at 20.15
20.15	Blanket brought	CCTV	Officer shown on Brixton Police Station custody corridor CCTV bringing blanket to the 'cage'
20.16	FME	CCTV	FME returns, hovers in corridor, leaves 20.19.08
20.16	**CAD 8289**	**Call for ambulance**	**Request for London Ambulance Service (LAS)**
20.19.17	**CAD 3063**	**Call for LAS**	**Request for ambulance: male not responsive and with mental health issues**
20.19.46	FME	CCTV	FME squats down by Mr Rigg
20.24.56	FME	CCTV	FME returns, enters 'cage' to examine Mr Rigg
20.25.47	Defibrillator	CCTV	Defibrillator brought to custody corridor
20.27.45	**CAD 8289**	**Call update**	**"Male got cardiac arrest. LAS please"**
20.29.40	CAD 8289	Call update	"Your ETA please. Male now got cardiac arrest"
20.33.58	CAD 8289	Call update	Response: LAS now on way
20.34.40	**CAD 8289**	**Call update**	**Have you an ETA please; male collapsed and officers performing CPR**
20.36.31	LAS	Brixton police	First ambulance crew arrived as shown on CCTV
20.43.32	LAS	Brixton police	Second ambulance crew arrived
20.57	Police/LAS	CCTV	Defibrillator removed and stretcher brought in
21.03	LAS	CCTV and LAS	Ambulance leaves police station yard after Mr Rigg carried out unconscious to ambulance
21.09	LAS		Ambulance arrived at Kings College Hospital where CPR continued in Accident & Emergency Department
21.24	Hospital		Mr Rigg pronounced dead at Kings College Hospital

Responses to the 999 calls

One of the missed opportunities identified by the IPCC investigation report was the failure of the first CCC call operator to recognise, at the outset, the seriousness of the initial call from the Penrose Hostel: the operator responded, "This is not a police matter."[127] As the IPCC account unfolds, the reader can understand the growing frustration of the hostel staff, who started calling before 17.00. During the following two hours, the staff grew increasingly anxious about Mr Rigg, but no police attended. After Mr Rigg left the hostel around 19.00, a further hour elapsed. The hostel staff did not call to identify when Mr Rigg left the hostel, at which point he constituted a risk to the public at large. The staff should at least have ensured that Ms Wood, the manager, was aware that Mr Rigg had left the hostel. When she made her final call to the police at 19.19, she did refer to him as being in the street, but was unaware that he had moved to another part of Brixton. The reader understands that, by then, the staff may have despaired of a response from the police.

The IPCC investigation did substantial work on the complex task of examining the CAD calls. The report's narrative account carefully documents a series of events representing missed opportunities concerning failures to link related calls promptly (some calls were more swiftly linked than others, as the integrated timeline above shows) and the limitations of the CCC system: since different individual operators were taking calls from the Penrose Hostel and calls from the public, the relationship between the two sets of calls was missed. The Review considers that the unusual information in both sets of calls (e.g. the man concerned was naked from the waist up) constituted a point of striking similarity. It is not beyond modern information technology to flag such similarities; the effectiveness of information technologies depends on how they are used.

The IPCC narrative also clearly indicates that several attempts were made to deploy police vehicles to the hostel calls, but without success (see timeline above). The IPCC investigation report determined that this was due to two factors: vehicles not indicating when they were not available to respond to calls and vehicles not responding. The IPCC notes that the response time was outside the standard established for police attendance. **This deserved to be firmly criticised.** If the police had arrived within two hours of the first 999 call from the Penrose Hostel, Mr Rigg would still have been at the hostel and the scenario would have been significantly different: both police and hostel staff would have been present, his mental health issues would have been known and, in all probability, he would have been processed under the MHA and taken to receive immediate medical attention.

Linking information

The IPCC report gives an account of the movements of police van LD2N with the four police officers who later apprehended Mr Rigg. There were four rather than two police officers in the van; apparently this was due to the fact that "two of the officers were still in their probation period that would be usually accompanied by two other experienced officers and so they would be 4 officers in the van instead of 2."[128]

[127] IPCC document D20.
[128] IPCC officer's report concerning the van operations on 21 august 2008, dated 5 November 2009, IPCC report R4D.

The van left Brixton Police Station at 19.24 according the van MDT: local CCTV captured the van at 19.27.14 proceeding down Brixton Hill with flashing lights, indicating that they were responding to a high priority incident. Two of the team of four officers stated in their IPCC interviews that they had started out from Brixton Police Station with CAD information about a male being aggressive to members of the public; the IPCC investigation identified this as CAD 6010.[129] The use of flashing lights cannot be explained as an urgent response to CAD 6010, which had come in much earlier, at 16.40 hours. The IPCC investigation did not have the text of CAD 6010 and did not look further into this.

At the Coroner's Inquest, PC Glasson referred to the van leaving to respond to two CAD calls. Under questioning at the Coroner's Inquest, PC Glasson conceded that the second CAD, received by the van team when they were leaving the station, was probably CAD 6148: CAD 6148 was from the Penrose Hostel and related specifically to Mr Rigg. The CAD 6148 log recorded that at 20.12 PC Birks reported "male no longer at scene"; the logic for PC Glasson's concession and this line of questioning possibly stemmed from the fact that PC Birks would not have been providing this information on CAD 6148 unless his team had been responding to CAD 6148. The Review considers that the account of the information the police team in LD2N van had when they left Brixton Police Station, and what information they subsequently obtained, has important gaps. For acts and omissions on the part of the police to have been fully probed, this point should have been pursued.

In his initial statement on the night of 21/22 August 2008, PC Birks said that the first call provided to his team related to a man 'kicking out' at Angus House. After attending the Angus House location indicated in CAD 6010, the van went on to the nearby location corresponding to the incident reported in CAD 7776. The data printout for the MDT in the police van[130] shows the van as slowing to a stop at 19.29.10 and moving again slowly at 19.31.24. This stop of over two minutes coincides with the accounts given in IPCC interviews by two of the officers[131] that the police van was responding initially to a call to Angus House on Atkins Road. When the IPCC interviewer asked whether this call was to do with Sean Rigg, PC Forward did not give a direct answer but stated that there was no sign of "anything that we were looking for". This was not pursued in this IPCC interview.

PC Glasson reported during his second IPCC interview that the team in the van had initially responded to a CAD, handed on paper to PC Birks, about "this male striking out and squaring out at members of the public";[132] when they arrived at Angus House there was no sign of the person indicated. PC Harratt stated during his second IPCC interview that people present at Angus House gave descriptions of a black or mixed race man "with white trousers and no top on".[133] From the similarities in the descriptions it is clear with hindsight that this man was, in fact, Mr Rigg. PC Harratt reported in his second interview that the team had "just relayed that back … and then immediately after the next call came out said, can you go to this one, it sounds similar": PC Harratt reported that the van was just pulling off when the next CAD came in.[134] PC Glasson stated in his

[129] Identified by an IPCC investigator as CAD 6010, IPCC report R4D.
[130] MDT MO1/3206.
[131] PC Glasson and PC Harratt.
[132] IPCC interview with PC Glasson, 26 March 2009, transcript p. 8.
[133] IPCC interview with PC Harratt, 26 March 2009, transcript p. 9.
[134] IPCC interview with PC Harratt, 26 March 2009, transcript p. 8.

second IPCC interview that when that CAD came in over the radio, "obviously the description fitted again so we, you know, realised it was the same male who just moved off down the road."[135] From examination of air wave material[136] to which LD2N responded, it is clear that this was CAD 7776.

PC Forward stated in his second IPCC interview that he had read out details of CAD 7776: "It's a male in white trousers has just tried to karate-kick a passer-by, he is wearing white trousers and with a bare chest."[137] It should be recalled that the two calls (CADs 7776 and 7789) from members of the public about a man of this description (Mr Rigg) attacking people in the street and performing karate moves were linked and that CAD 7789 contained the annotation by the CCC operator "must have mental health issues" (see *An integrated timeline of events*): that vital annotation was added at 19.34 hours: before the police in the van spotted Mr Rigg in the street.

PC Forward explained that, as they were close to the location reported in CAD 7776, they proceeded down Atkins Road and were flagged down by members of the public indicating that the van should go into Weir Road, where the police first spotted a man who answered the CAD description. This information was gathered by the IPCC at interview: a critical analysis could have revealed the implications of that information and should have given rise to major concern.

Inspector Dunn, in his evidence to the Coroner's Inquest, stated that "My expectation was then that those officers would familiarise themselves with any risks associated with those calls … they should make themselves familiar with all the circumstances of the incident they are attending."[138] He explained that the information would have been available on the MDT in the van and that officers were expected to check that information when they went out in response to a CAD.

The IPCC report records that the officers deny knowing that the person they arrested was Sean Rigg: the IPCC concludes that there is no reason to doubt their statements. The IPCC report does not conclude that this ignorance of Mr Rigg's identity was the result of their failure to check the linked information about the CAD to which they were responding. **Since checking CAD information is standard practice when operating in response to a CAD call, more robust criticism in the IPCC report might have been expected about the officers' failures to carry out these checks.**

At the Coroner's Inquest, this issue was probed at length and it was confirmed that the operational police team responding and apprehending Mr Rigg failed to check and cross-check the information available in the CAD calls through the MDT. PC Glasson, the officer designated as the MDT operator, gave evidence at the inquest that there were problems with the MDT in the van and that it was not working throughout the period from when the van left Brixton Police Station until it returned with Mr Rigg and the four police officers; instead, the team communicated by radio.[139] However, PS Tribe testified at the inquest that the van's MDT was not defective that evening.[140]

[135] IPCC interview with PC Glasson, 26 March 2009, transcript p. 9.
[136] IPCC document D223.
[137] IPCC interview with PC Forward, 18 March 2009, transcript p. 8.
[138] Evidence of Inspector Dunn, Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 20 July 2012, transcript pp. 20-21.
[139] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 28 June, transcript p. 28.
[140] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 13 July 2012, transcript pp. 144-145. PS Tribe testified that a defect had been found in the van's MDT on the morning of 21 August 2008 but that it had been replaced and the new MDT in the van was in full working order by late morning.

Although the broad outline of what happened emerges from the IPCC interviews, there are discrepancies between the accounts. The four officers differ as to whether the link between the two CAD calls was made by the operator or by the police team in the van. These differences were not fully explored in IPCC interviews. The IPCC asked some questions about the CAD calls, but the questioning and follow-up in subsequent interviews was inadequate concerning the failures of all four police officers to check other information on the system (i.e. on the MDT or by radio) that might have helped them to identify, at an early stage, the person they were pursuing either as Mr Rigg or as someone with mental health problems.

The integrated timeline shows that, when the van was deployed on CAD 7776 at 19.32, the CAD had already been linked to CAD 7789 at 19.31; the annotation "must have mental issues" was added at 19.34, three minutes before the van stopped at 19.37.24 in the road where Mr Rigg was spotted. One of the IPCC investigators carried out a test in the van to see how the information could be checked on the MDT.[141] **This was a good piece of investigative work by the IPCC.** She found that it took about two minutes for the additional information available to load on the screen and concluded that it was possible that the van arrived before the information loaded on the MDT screen.

However, the time available to check the CAD information was not limited to the initial period when the van was going to the scene. Mr Rigg was with the police officers for an extended period at the scene of arrest, on the journey back to the police station, in the van in the station yard, and in the custody holding area. The Review stresses that PC Glasson, as the designated operator in the van, might have been expected to check the information on the system, but this was not pursued by the IPCC at interview. Four years later, his explanation at the inquest for failing to check the information on the MDT was that he was unable to make the MDT work;[142] PS Tribe's evidence at the inquest showed that this was not due to any defect in the MDT. The failure to check the available information was an important missed opportunity: had Mr Rigg's mental health problems been identified earlier, action might have been possible to avert the tragedy of his death.

Other information about the CAD calls linking the incidents of violence in the street with both the identity of Sean Rigg and signs of mental illness was potentially available to the IPCC from Inspector Dunn. This did not emerge in the IPCC investigation report because the statement provided to the IPCC by Sergeant Dunn in early January 2009[143] does not include the information he later provided during lengthy questioning at the Coroner's Inquest.[144]

At the inquest, Inspector Dunn (who at the time was the section sergeant at Brixton Police Station) stated that, when he came on duty at 19.00 on 21 August, he had been asked to look at a series of linked CAD calls received during that late afternoon/evening: the information in the linked CADs included the name of Sean Rigg and the automatic prompt that mental health issues could be involved. Inspector Dunn requested a unit to be assigned to respond to the linked series of CADs: "the fact it involved somebody who appeared to be suffering signs of mental health illness and the

[141] Report dated July 2009, IPCC report R4C.
[142] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 20 July 2012, transcript pp. 90-91.
[143] IPCC statement S69.
[144] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 19 July 2012, transcript pp. 185-216, and 20 July 2012 transcript, pp. 5-61.

fact that there were people were requesting repeatedly saying, this person is attacking us, I felt it was appropriate we got people there immediately."[145] Inspector Dunn appears to have been remembering the Penrose Hostel CAD calls: there may have been some confusion after the passage of four years between these calls and the calls from the public about attacks in the street.

The IPCC investigation report did not explore fully who was supervising the integration of CAD information and operations at a senior level at Brixton Police Station. Inspector Dunn could have been questioned about this, at an early stage, in order to establish the timeline and the responsibility for the communication and use of the intelligence from both sets of calls.

C. Identifying Mr Rigg

There is no dispute about the fact that, at the time of his apprehension, Mr Rigg was searched while restrained on the ground and that the police found a passport on him. This is attested to by the police officers involved, as well as by members of the public who witnessed this.[146] The passport was a concrete piece of evidence whose significance was largely overlooked by the police until too late. It is a matter of concern that the significance of the passport is not emphasised in the IPCC investigation report. It is not even clear from reading the IPCC report that the passport was, in fact, Mr Rigg's own old passport. The Review presents the following analysis to illustrate this point.

The Passport

Like all UK passports, the back double pages of the passport have a photograph on the left and personal details on the right showing that the passport belongs to Sean Nicholas Rigg, born in England in 1968. The date of issue, 30 July 2002, made the passport clearly six years old at the date of Mr Rigg's death. The expiry date, 30 July 2012, had not been reached, but the top corners of the front and back cover had been officially cut off on the diagonal, rendering the passport invalid. The passport photograph shows a black man in his mid-thirties. The review is of the opinion that it looks like Mr Rigg as portrayed at the time of his death in August 2008, allowing for the passage of six years since the photograph was taken in 2002.

The IPCC report presents accounts by PC Forward[147] and by PC Harratt[148] of PC Harratt searching Mr Rigg and finding a passport: "I found the passport and I thought it didn't look like him so I arrested him on suspicion of theft."[149] PC Birks, the senior officer in the arresting team, later

[145] Evidence of Inspector Dunn, Coroner's Inquest, 20 July 2012, transcript p. 22.
[146] Coroner's Inquest, 22 June 2012, transcript p. 14 and p. 44.
[147] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, p. 120, para. 37. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[148] IPCC investigation report, p. 124, para. 39.
[149] IPCC interview with PC Harratt, 26 March 2009, transcript p. 26.

conceded at IPCC interview that "in sort of a more controlled environment [at the police station] it was clear to see that it was him."[150] At the Coroner's Inquest, PC Glasson[151] stated that it was only later, at the police station, that the passport was confirmed as being that of Mr Rigg: similarly, PC Birks confirmed that he did not check the passport at the scene of arrest on the assumption that the police officer who found it and his colleagues knew what they were doing. He checked the passport only later, at the police station.[152]

At the Coroner's Inquest, questioning robustly probed both the basis for the police officers' conclusion that the person they had apprehended was not Mr Rigg and how they compared the photograph with him. The officers were also asked why none of them radioed to check the passport (e.g. to see if the PNC included information about why it had been officially invalidated).[153]

The IPCC briefing for the March 2009 interviews with the police officers who attended the arrest scene includes, in the list of points to be covered, the question "Why did the officers believe the passport to be stolen?" The transcripts of the interviews with the police officers reveal that some questions about the passport were asked, but no attempt was made to go into detail. For example, at his second IPCC interview PC Forward volunteered (without a specific question about the passport) the following statement: "At this point I think PC Harratt searched his [Mr Rigg's] back pockets and finds an old passport which he doesn't think looks like him so Mr Rigg is further arrested for theft I think."[154] The interviewing IPCC investigator responded "Yes" and then the interview moved on without further reference to the passport. There is no record in any of the transcribed interviews that the IPCC explored further the officers' statements that they did not think the person in the passport photograph was Mr Rigg. Similarly, when PC Harratt explained "it didn't look like him … because he had … more hair, was a slightly chubbier face", the IPCC interviewer replied, "Right, that's fine" and moved on to other issues.[155]

The passport should have rung immediate alarm bells with the IPCC (even if it reportedly did not do so for the police officers involved in the apprehension). Mr Rigg was charged by the police with theft of the passport at the scene of apprehension, although an invalid passport would have, at best, limited value as stolen property. IPCC investigators are required to test evidence on the basis of the balance of probabilities: they concluded that the police did not know that they were dealing with Mr Rigg.

This missed opportunity to identify Mr Rigg was pivotal. If the police officers had accepted the evidence of the passport, they would have known that the person they were arresting was Sean Rigg. If they had bothered to check the passport and/or the PNC database record of the person named in the passport, the information on Mr Rigg, including information about his mental health, would have been discovered.

[150] IPCC interview with PC Birks, 18 March 2009, transcript p. 24.
[151] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 28 June 2012, transcript pp. 67-73.
[152] Coroner's Inquest, 5 July 2012, transcript pp. 138-140 and 161-162.
[153] Coroner's Inquest, 29 June 2012, transcript p. 77ff.
[154] IPCC interview with PC Forward, 18 March 2009, transcript p. 15.
[155] IPCC interview with PC Harratt, 26 March 2009, transcript p. 26.

The IPCC investigation report contains only one reference to the passport: at paragraph 124 it records PC Harratt's account of searching Mr Rigg, finding a passport, believing that the passport photograph was not of Mr Rigg, and arresting Mr Rigg for theft of a passport. Given the potential importance of the passport as a means of early identification of Mr Rigg, this is a serious omission in the report.

The IPCC investigators interviewing the police officers who attended the scene were inadequately briefed concerning the importance of the passport: the interviews did not fully probe the accounts given by the officers. They also did not challenge the plausibility of the conclusions reportedly drawn by the police officers. Therefore, the IPCC investigation report did not adequately address this important matter. **The Review considers that, at the very least, the report should have raised concerns (for future examination by the Coroner or others) as to (i) the plausibility of the police officers' accounts of their handling of the passport, and (ii) their failure to identify Mr Rigg using this piece of concrete evidence.**

The failure of the police officers to establish the identity of Mr Rigg at an early stage in his detention, despite finding his passport on his person, had obvious implications for identifying Mr Rigg as a person with mental health needs.

The IPCC investigation report does not establish when Mr Rigg's identity became known to the police. When the Review examined the IPCC's analytical chart (mapping statements by police officers, hostel staff and witnesses against CAD logs and CCTV), it found a reference to CAD 8289 (see *An integrated timeline of events*) at 20.16 hours requesting an ambulance. This call was updated at 20.19 as an ambulance request for a male with 'mental issues'. It was then updated again at 20.25 with the information that the male had suffered cardiac arrest. The IPCC document relating to this CAD[156] records that officers were performing CPR and that attempts had been made to reach the DPS *and Mr Rigg's next of kin*. **The Review sees this as an important piece of information, meriting inclusion in the IPCC investigation report, since by this time the police must have known the identity of Mr Rigg.**

D. Identifying Mr Rigg as a person with mental health needs

If the police had accepted the evidence of the passport as to Mr Rigg's identity and/or checked the PNC for 'Sean Rigg', they would have found details of his mental health history; Mr Rigg was known to the Brixton police because of past offending, including violence against the person (in particular assault against the police) and mental illness.

Even without the passport evidence as to his identity and the link to his mental health history, the question remains as to whether or not there were indications that the person described in the CAD calls and arrested by the responding police officers displayed signs of mental health needs. Guidance on good practice in relation to safer detention was updated by the Association of Chief

[156] IPCC document D27. This refers to CAD 8289, which was entered at 20.16 hours 21 August 2008, reference C10.

Police Officers in 2012 and includes pre-custody assessment: "When responding to an incident the risk assessment should start with gathering available information on the way to the scene."[157]

The IPCC interviews with the four police officers attending the arrest scene included questions that point towards the fact there were indications of mental health problems. However, initial interview responses by the police officers concerning what they observed about Mr Rigg were not followed up adequately. At no point were the police officers asked explicitly about their understanding of what constituted indicators of mental illness.

Guidance on policing and mental health issues

Although the guidance applicable at the time was weak with regard to identifying persons with mental illness, it did stress both (i) mental illness as one of the underlying reasons for violent or agitated behaviour, and (ii) the need to treat persons as medical emergencies "if there is any suspicion that the violence stems from a medical condition" (the guidance makes clear that "medical condition" includes mental illness).[158]

In the aftermath of Mr Rigg's death, the Review welcomes the progress made in improving the guidance now available concerning behaviour that might accompany mental illness in a public place.[159] Elements revealed in the IPCC investigation match several of the indicators for mental illness currently included in the guidance, for example

- removing clothing for no apparent reason,
- being unresponsive to others,
- engaging in threatening behaviour towards others for no obvious reason, and/or
- presenting an immediate risk of harm (e.g. assaults on others).

The Review understands that in 2008 these elements were not spelt out in the guidance for police officers, as they now are. From the description of Mr Rigg's behaviour, as reported in the IPCC investigation report, the reader is drawn to the conclusion that the police officers would have at least suspected that he was mentally ill. However, the report itself does not express this conclusion. According to the applicable guidance, suspected mental illness should have triggered a different response on the part of the police, such as consideration of using Section 136 of the MHA (i.e. police holding powers).[160] **The Review welcomes (i) new measures to help identify mental health issues**

[157] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006, Section 2.2.
[158] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006.
[159] ACPO and Home Office, 'Guidance: The Safer Detention & Handling of Persons in Police Custody' (second edition), 2012. Available at http://www homeoffice.gov.uk/publications/police/operational-policing/safer-detention-guidance?view=Binary.
[160] Mental Health Act 1983. Available at http://www.legislation.gov.uk/ukpga/1983/20/contents. Revised 2007: available at http://www.legislation.gov.uk/ukpga/2007/12/contents.

at any early stage of contact with the police, and (ii) the diversion options flowing from the Bradley report.[161]

Abnormal aspects of Mr Rigg's behaviour were evident from the very outset. It required only intelligent attention by the police officers to suspect mental illness from what was reported to them and, later, what was before their eyes: the person concerned was on the street naked from the waist up, he was performing karate moves in public, attempting to attack strangers in the street, and he did not utter a word to the police officers.

Lack of sufficient clothing

The IPCC investigation report documents various accounts, including those by the police officers attending the scene, that all attest to the fact that on the evening of 21 August 2008 Mr Rigg was in public wearing only white/pale trousers but no shirt.[162]

The IPCC investigation report does not refer to the weather conditions that August evening, nor do the internal notes, possibly because the investigators remembered what the weather had been like that evening. Official data for 21 August 2008 show that it was windy, warm and humid with a little rain, but it would have felt cooler with the wind factor.[163] As evening came on, the temperature would have been falling. The critical time was after 19.00 hours. The footage from the external CCTV at the Penrose Hostel shows Mr Rigg outside the basement door of the hostel at 19.01, naked from the waist up.

Examination of the footage of the street CCTV cameras in the area where Mr Rigg went on that evening shows that Mr Rigg was the only person naked from the waist up and most of the pedestrians and other members of the public shown on the CCTV were wearing long sleeves, often with more than one layer of clothing on the upper body. This is what the police officers attending the scene would have seen. The officers themselves were wearing summer uniforms consisting of short-sleeved shirts under heavy protective vests (body armour).[164]

In the IPCC interviews, questions were posed about Mr Rigg's clothing. For example, PC Birks was asked to describe what Mr Rigg was wearing. He replied, "he was only wearing white or beige-coloured trousers and I remember him having a pair of socks on as well."[165] The interviewer responded "Right" and PC Birks said, "That's the only clothing I remember him wearing." This could be construed a number of ways.

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[161] Lord Bradley, Lord Bradley's review of people with mental health problems or learning disabilities in the Criminal Justice System, 2009. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694.

[162] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 96 (the CCTV at the hostel), para. 103 (the street CCTV), para. 109 (a member of the public), and para. 110)Mr Jung, another member of the public). Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

[163] Wind speed 16 km/h, with gusts up to 41 km/h, average humidity 73%, with 0.22mm rain, mean temperature 18 degrees Celsius (maximum temperature 22, minimum 14), which was slightly higher than the average temperature for August 2008. Met Office statistics and data from the Weather Underground website.

[164] As shown in the CCTV footage at Brixton Police Station and in photographs taken by a witness at the Weir Estate.

[165] IPCC interview with PC Birks, 21 January 2009, transcript p. 5.

This line of questioning was not followed up and the interview immediately moved on to other matters. There was no clarification of whether PC Birks was confirming that Mr Rigg was wearing nothing on his upper torso or that the officer was only able to remember those items of clothing. It might be that, with the passage of time, some items of clothing could have been forgotten, but it is unlikely that a police officer would forget that the person in question was naked from the waist up. This point and its implications needed to be established precisely. No question was put to PC Birks about his view of the fact that Mr Rigg was wearing only the clothing described. PC Birks would be expected to know that lack of clothing in public is one of the indicators of possible mental illness. Moreover, as the senior officer attending the scene, he would be expected to take the lead in assessing risk indications, including possible mental illness.

When PC Forward was interviewed, there was no questioning about Mr Rigg's clothing.
In his first IPCC interview, PC Glasson was asked for a description of the person they were looking for. PC Glasson replied that it was an IC3 male (African/Afro-Caribbean person)[166] wearing white or light-coloured trousers, brown shoes "and naked from the waist upwards".[167] The IPCC interviewer's response was "Right, so quite easy to spot" to which PC Glasson responded, "Yeah." This could have introduced an important line of questioning about whether this appearance was normal or unusual, and what this lack of adequate clothing might have meant. The interviewer did not pursue this line of questioning but at once moved on: "Okay, so he's run off, having seen you, into the Weir Estate. What do you do?" There was no return to the issue of Mr Rigg's lack of adequate clothing.

In his second IPCC interview, PC Glasson again mentioned the description provided in the CAD call: "It was obviously a very odd description because he'd been described as naked from the waist upwards."[168] This "oddness" was not pursued.

In PC Harratt's second interview, he described the moment when the police responding to CAD 7776 spotted Mr Rigg: "We all pretty much near enough at the same time said, Oh that looks like him, bare chest, white trousers."[169] This lack of clothing was not pursued in questioning at this point, but later the interviewer did come back to it: "So when you saw Sean Rigg you said he was bare-chested with white trousers. Is that similar to what you see in this photograph, in the top photograph here? What state were the trousers in, were they torn, dirty, grubby? Can you remember?"[170] The interview moves on to questions about Mr Rigg's state of dishevelment and possible injuries, but not to the lack of clothing as an indicator of mental illness.

None of the police officers disputed the fact that Mr Rigg was naked from the waist up. Opportunities for the IPCC to explore the implications of this were not taken. The written briefing for interviewers lacked analytical content, being merely a list of points to be covered in the

[166] The Home Office statistics on race use the following classification system: IC1 – White person, northern European type; IC2 – Mediterranean European/Hispanic; IC3 – African/Afro-Caribbean person; IC4 – Indian, Pakistani, Nepalese, Maldivian, Sri Lankan, Bangladeshi, or any other (South) Asian person; IC5 – Chinese, Japanese, or South-East Asian person; IC6 – Arab person; IC0, IC7 or IC9 – Origin unknown.
[167] IPCC interview with PC Glasson, 22 January 2009, transcript p. 6.
[168] IPCC interview with PC Glasson, 26 March 2009, transcript p. 8.
[169] IPCC interview with PC Harratt, 26 March 2009, transcript p. 11.
[170] IPCC interview with PC Harratt, 26 March 2009, transcript p. 18.

interviews, with no explanation of the lines of questioning to be pursued. The written briefing did not refer to the MPS guidance about mental illness.

Not speaking a word throughout police contact

The evidence of all four officers involved at the arrest scene is consistent regarding Mr Rigg's failure to speak. **The IPCC was thorough in documenting this in the interviews with the police officers concerned.**

> PC Harratt: "He never said a word to us."[171]
> PC Forward: "The officers were talking to Mr Rigg. He made no response to anything that they said."[172]
> PC Birks: "He didn't speak … I tried to explain what was happening … and he didn't seem to acknowledge anything."[173]
> PC Glasson: "I did try to talk with him, just to try to get some reaction out of him … but got no reaction other than the occasional grunt."[174] "He made a few sort of grunting noises."[175]

Based on the police officers' accounts, the IPCC report describes how on the two mile journey in the van Mr Rigg said nothing, looked at officers periodically when they spoke to him, and made occasional growling noises.[176] As Mr Rigg was held waiting in the parked van at Brixton Police Station, and then removed from the police van to the holding area adjacent to the custody suite, he continued to remain silent: "He still hadn't spoken to us."[177]

As the IPCC investigation report emphasises, Mr Rigg did not speak at any time during police contact (i.e. from after 19.37 when the police answering the CAD call first spotted him, during apprehension, restraint, arrest, escort to the police van, transport in the police van, and detention at the police station) until he left the police station by ambulance at about 21.00. **The passage of time made this indication of mental health issues all the more compelling.**

> PC Harratt: "He never said anything the whole time".[178]
> PC Harratt, when asked in his second interview whether Mr Rigg said anything at any point at all: "No, from start to finish … Absolutely not, never said a word."[179]
> PC Forward: "Throughout the incident he said nothing to us."[180]
> PC Glasson: "He never spoke throughout the incident."[181]

[171] IPCC interview with PC Harratt, 19 January 2009, transcript p. 16.
[172] IPCC interview with PC Forward, 26 January 2009, p. 12.
[173] IPCC interview with PC Birks, 18 March 2009, transcript p. 15.
[174] IPCC interview with PC Glasson, 22 January 2009, transcript p. 8.
[175] IPCC interview with PC Glasson, 22 January 2009, transcript p. 9.
[176] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 173. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[177] IPCC interview with PC Glasson, 26 March 2009, transcript p. 29.
[178] IPCC interview with PC Harratt, 19 January 2009, transcript p. 9.
[179] IPCC interview with PC Harratt, 26 March 2009, transcript p. 43.
[180] IPCC interview with PC Forward, 26 January 2009, transcript p. 20.
[181] IPCC interview with PC Glasson, 22 January 2009, transcript p. 15.

The IPCC interviews did not sufficiently explore how Mr Rigg's sustained failure to speak was viewed by the police officers. The written IPCC briefing for the interviews with the police officers did not focus on this aspect. Reconstructing the IPCC investigation now, it would appear that, because this issue was not explored sufficiently at interview, the report drafter felt unable to address the police officers' failure to see this sustained absence of speech on the part of Mr Rigg as an indicator of a mental health problem, although the drafter of the IPCC investigation report clearly considered Mr Rigg's failure to speak as grounds for concern about mental health issues.

PC Harratt gave an account of his attempt to gain a response from Mr Rigg by applying the mandibular force technique.[182] This is a defensive technique used to enforce compliance in the face of aggression rather than to test responsiveness; an appropriate test of responsiveness would be pinching and slightly twisting the skin of the wrist or arm. The technique used on Mr Rigg failed to elicit a response. Interestingly, the IPCC did not question this use of a compliance enforcement technique as a test of responsiveness.

Performing martial arts moves in public and attacking members of the public

The IPCC investigation report documents that the local authority CCTV showed Mr Rigg, before his arrest, walking along Brixton Hill, stopping for about 10 seconds to do some martial arts kicks and punches and then moving on.[183] Mr Rigg was subsequently caught on CTTV walking into the centre of the road and taking up a martial arts stance with legs spread, knees bent, arms over his head to one side and elbows bent; he held the pose for a few seconds and then returned to the pavement.[184]

During his second IPCC interview, PC Forward reported that the 7776 CAD call to which the police officers responded described Mr Rigg as attempting to karate kick passers-by.[185] When the police van arrived in the area, it was flagged down by a woman pedestrian who reported that a black man had attempted to hit her and was now walking down the road.[186] At around the same time, the 999 calls by Witness A (CAD 7776) and by Mr Jung (CAD 7789) report an attack using karate kicks by a man answering Mr Rigg's description.[187]

When the IPCC put to PC Forward that being violent and doing karate kicks was "all quite unusual behaviour",[188] he agreed. Then, when asked whether anyone had considered calling an ambulance, PC Forward answered, "An ambulance for whom?" The interviewer responded "for Sean Rigg or for yourself". PC Forward replied, "As far as I was aware he wasn't injured, so I didn't call an ambulance." The interviewer said, "OK. That's fine" and moved on to other matters. This is an example of an attempted line of questioning that is not pursued. The interviewer seems to avoid pressing the point.

[182] Statement dated 22 August 2008, IPCC statement S7.
[183] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 100. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[184] IPCC investigation report, paras 105 and 106.
[185] IPCC interview with PC Forward, 18 March 2009, transcript p 8.
[186] IPCC interview with PC Forward, 18 March 2009, transcript p. 9.
[187] IPCC investigation report, paras 109 and 110.
[188] IPCC interview with PC Forward, 18 March 2009, transcript p. 35.

Additional indications of mental health issues

In addition to these indications of mental health issues, Mr Rigg's behaviour in the police van was emphasised in the IPCC report. Various accounts by the police officers in the van describe him as being on his back on the floor between the two benches in the cage, cuffed in the stack position (i.e. with hands cuffed behind his back) with his legs up and feet against the walls of the cage. PC Forward described Mr Rigg as spinning around on the floor.[189]

The IPCC investigation report includes photographs of the inside of the van showing how cramped it was, but did not include the measurements of the van cage. The Review team examined a van identical to LD2N, the van used to transport Mr Rigg: the U-shaped space between the bench seats in the van cage was very limited, measuring 88cm x 68 cm, with the seats 43cm in height. The Review team fails to understand how it was possible for Mr Rigg to have done what he was described as doing: the Review team attempted to replicate Mr Rigg's reported behaviour in the caged area with the van doors closed. The dimensions do not allow a person to spin while lying on his back in the footwell. The Review also obtained an opinion from an expert in dance training, including break dancing, who indicated that, in order to rotate while lying on the upper torso with legs up, the hands must be free for momentum and balance. To anyone who has tried to replicate Mr Rigg's alleged actions, the report that he spun around in the footwell in the position described is not believable and calls into question the veracity of the accounts.

The reported position and movements of Mr Rigg in the van cage were bizarre in the extreme and merited a response on the part of the police officers, both as a sign of mental health problems and as a potential health and safety problem. According to the MDT, the van was driving at speeds of up to 63mph (with blue lights on) as it returned to Brixton Police Station. Even when a police van is motionless, a person restrained with cuffs in the stack position in the footwell of the cage, with legs up and feet on the walls, must experience significant pressure on the neck and/or shoulders and breathing is compromised: the position is extremely uncomfortable when the van is stationery. In a moving van, it would be painful and involve risk of injury to the person.

The report that Mr Rigg continued this behaviour over the course of the journey and while waiting in the van in the Brixton Police Station yard would give a strong indication that he was suffering from serious mental health problems such as would inhibit the normal awareness of the signs of stress from one's own body that such actions would inevitably cause. Maintenance of that position would have involved considerable physical exertion for the period described by the police officers: during the van's journey, which lasted six minutes, and at least part of eight to eleven minutes while waiting in the van in the police station yard (see *An integrated timeline of events*).

PC Harratt who, like PC Forward, was seated in the back of the van, with a view of Mr Rigg, stated that "He'd slumped in his seat and then he sat in the foot well"[190]; "he was kicking … the cage and basically using his legs to run round the side of the floor."[191] The Review is concerned that the behaviour described, including the grunting and groaning heard by the officers, might conceivably have been vain attempts by Mr Rigg to extricate himself from the footwell, in which he was wedged

[189] IPCC interview with PC Forward, 18 March 2009, transcript p. 20.
[190] IPCC interview with PC Harratt, 26 March 2009, transcript p. 21.
[191] IPCC interview with PC Harratt, 26 March 2009, transcript p. 21.

on his back, while impeded from rising by the fact that his hands were cuffed behind his back: his breathing may well have been compromised by his position and his actions may have represented attempts to seek relief. It is not possible to be certain about what happened in the van but, at the very least, the police officers' own accounts, as recounted in the IPCC investigation report, must raise questions as to why the officers who were supposed to be monitoring Mr Rigg's well-being did nothing to prevent him from incurring harm in this risky position as the van sped on its return journey.

IPCC attempts to address the question of recognising mental health issues

There were attempts by the IPCC interviewers to address the identification of Mr Rigg as a person with mental health issues. There is no specific mention in the IPCC interview briefings of criteria for identifying mental illness, but the issues of Mr Rigg's lack of clothing, his not speaking throughout, his martial arts moves in public, his attacks on passers-by, and his strange behaviour in the van cage were all brought up in IPCC interviews.

In the second interview with PC Forward, the IPCC repeatedly attempted to raise the question of Mr Rigg's mental health needs. PC Forward stated that "there's nothing more significant than as I say he was spinning around on the floor."[192] Later the interviewer tried again: "did you have any thoughts about his - he's not okay or he's not being violent now so he's possibly okay. Or when he was violent did you think he might be ill or did anything sort of strike you that you thought at the time?" PC Forward replied, "When he was being violent I was considering that maybe he had taken drugs or something, that's why he was acting in this fashion … He was either angry, drunk or he had mental health issues … But once he attacked me, I was defending myself. I was still staying professional, I didn't lose my temper or anything like that, what I said, as I say all I was trying to do was to stop him from hitting me … My thoughts of why he was doing it weren't paramount to what I was doing at that time."[193] At this point, the interviewer accepts PC Forward's answer and moves on to other matters.

Subsequently, the question of possible mental health problems arose again when PC Forward was describing that, at the police station, a blanket was brought to the holding area for Mr Rigg on the instructions of the FME: "Did anybody say at the time that 'This man may have mental health issues'. Can you remember anything being said about that?"[194] PC Forward replied, "Not that I can recall, no" to which the interviewer responded, "Okay, that's fine" and moved on.

When asked about his training, PC Forward stated, "Also with regards to mental health, I'm not an experienced mental health worker"; the interviewer interjected "No" and PC Forward continued "so all I can say is we were trained and I reacted to the incident as well as I could."[195] This would have been a suitable point at which to ask specific questions about what, from his training, PC Forward would have considered to be indicators of mental health issues; this could then have been compared with both the applicable guidance and the signs exhibited by Mr Rigg.

[192] IPCC interview with PC Forward, 18 March 2009, transcript p. 20.
[193] IPCC interview with PC Forward, 18 March 2009, transcript p. 22.
[194] IPCC interview with PC Forward, 18 March 2009, transcript pp. 26-27.
[195] IPCC interview with PC Forward, 18 March 2009, transcript p. 30.

The second interviewer returned to the issue of mental health towards the end of PC Forward's interview, probing whether the officers discussed this issue:[196] "you said that when you were sort of thinking about it and before he started attacking you, you thought he could either be drink, drugs and mental health, but then after he attacked you stopped thinking about any of the reasons, you were just concentrating on that?" PC Forward answered, "Yes". The interviewer continued, "When you had assistance from your colleagues, did any of you then discuss the fact that he might have mental health problems at all?" PC Forward answered, "I don't think I did discuss it. As I've said, we were just concentrating on keeping Mr Riggs [*sic*] safe and well and taking him into custody. Whatever is affecting him could be assessed and he'd be in a place of safety."

The IPCC's attempts to address the question of Mr Rigg's mental health, and what the police officers might reasonably have been expected to know or consider about it, were made more difficult by the failure of the Police Federation (PF) representative to adhere to the limits of his role at interview. The following example[197] is indicative:

> IPCC interviewer (trying to ask what might be indicated by the fact that Mr Rigg was wearing): " … just a pair of trousers and shoes, not wearing a top and growling not speaking…things like that you know indicate-"
> PF representative (interjecting): "could indicate an awful lot of things."
> IPCC interviewer: "Yeah."
> PF representative: "there is no way that these officers could have known that, is there".
> IPCC interviewer (addressing the police officer): "You have said that you considered that it may have been drink, drugs or mental health issues, so you obviously knew this wasn't the person acting normally."
> PF representative: "what's normal?"
> The PF representative later stressed that there were "no obvious physical indications that he [Mr Rigg] had any mental health needs."

The Review considers these actions inappropriate and outside the limits of the PF representative's role (see *The role of the Police Federation representative*).

In his second IPCC interview, PC Birks stated the following: "I don't remember anything about him having mental health problems."[198] In his second IPCC interview, PC Harratt maintained that he did not view Mr Rigg as having mental health problems; he saw him as "fit and healthy."[199] In his second IPCC interview, PC Glasson stated that "Unfortunately we have a lot of people in the Lambeth Borough that have got mental health issues, so it is always something that is one of our considerations."[200] The approach described by PC Glasson seems to be in accordance with the police guidance applicable at the time.

If mental health was always a consideration in relation to persons being dealt with by the police in Lambeth, the statement by PC Forward to the IPCC that the team of officers did not discuss mental

[196] IPCC interview with PC Forward, 18 March 2009, transcript pp. 33-34.
[197] IPCC interview with PC Forward, 18 March 2009, transcript of second tape, p. 4.
[198] IPCC interview with PC Birks, 18 March 2009, transcript p. 21.
[199] IPCC interview with PC Harratt, 26 March 2009, transcript p. 42.
[200] IPCC interview with PC Glasson, 26 March 2009, transcript of second tape p. 7.

health in relation to Mr Rigg is surprising.[201] None of the other three officers mentioned any such discussion in their IPCC interviews and this question was not pursued by the IPCC in interviews. According to the accounts provided to the IPCC, each of the four officers must have independently concluded that Mr Rigg was not suffering from mental illness, without there being any discussion. **The Review considers that the IPCC might well have found this implausible on the balance of probabilities.**

The IPCC investigation report contains a discussion couched in tentative language concerning what was, in reality, a signal failure on the part of the police officers to recognise Mr Rigg's mental illness. This is quoted at length because it is of particular importance:

> It is of some concern that following Mr Rigg's arrest, none of the officers involved considered the possibility that there may be an underlying cause for his behaviour. The behaviour of Mr Rigg in the back of the van, as explained by the officers, would be described as strange by anyone's standards. PC Forward also recalls that Mr Rigg made the occasional growling noise whilst in the van.
>
> To summarise, the officers were aware that Mr Rigg was walking the streets semi-clothed attacking people and performing martial arts moves, he evaded arrest, assaulted a police officer and resisted arrest. The officers witnessed his behaviour in the back of the van. Mr Rigg had been occasionally growling and did not speak to anyone during the course of the whole incident. Despite all the above indicators, none of the officers considered the possibility that Mr Rigg may have been suffering from a mental illness.
>
> If this possibility had been considered, then according to the Standard Operating Procedures, where an individual with a mental illness, "… resists the restraint in a violent prolonged manner the physical stress on the person's body may result in death. Therefore in all such cases the police officer(s) concerned must treat the situation as a medical emergency and obtain emergency medical care […]
>
> The officers insist they did not realise that Mr Rigg was suffering from a mental illness, and there is no evidence to suggest that their assertion is not true.[202]

The IPCC presumably reached this conclusion on the balance of probabilities. Again it would seem that the failure to explore this matter further in the interviews with the police officers inhibited the drafter of the IPCC investigation report from reaching a different conclusion.

The Review considers that there were other conclusions to be drawn, even given the absence of detailed exploration of the matter at interview. The police officers asserted that they did not recognise the indicators of Mr Rigg's mental illness. The indicators were manifest and arguably not difficult to recognise, especially over the extended time period during which Mr Rigg was detained under restraint by the police. As the Commissioner's Foreword points out, "the officers who arrested Mr Rigg did not recognise him as a person with mental health problems despite his behaviour both

[201] IPCC interview with PC Forward, 18 March 2009, transcript p. 34.
[202] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, paras 427-432. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

before and after arrest. If they had recognised this, they should have activated the force Standard Operating Procedures then in place to deal with an individual with mental health issues, so that medical assistance was requested as soon as possible."

It is not strictly accurate for the IPCC report to conclude, as quoted above, that none of the police officers considered the possibility that Mr Rigg may have been suffering from a mental illness; rather, from the evidence gathered by the IPCC, it was open to the IPCC to conclude that, although the officers always considered mental health as a possibility, each of them decided separately and without discussion that the issue of mental illness did not apply in Mr Rigg's case.

The IPCC did not have the benefit of the detailed evidence available from the Coroner's Inquest, including the testimony given by the arresting police officers under more robust and focused questioning. At the Coroner's Inquest, PC Glasson stated that the van had returned to the police station with blue lights on because the officers decided "to get him [Mr Rigg] to custody as quick as possible and at least get some mental advice."[203] On cross-examination, PC Glasson agreed that it was at this point that they thought Mr Rigg might be mentally ill and that they might therefore need urgent advice. When asked whether this was discussed with his colleagues, PC Glasson said, "Yes, I mean, we are talking brief, because literally we get in the van, he starts doing that, one of the PCs radioed from the back of the van."[204]

Even without the evidence from the Coroner's Inquest, **the Review considers that there were a number of concerns to be raised by the IPCC**: (i) the position adopted by the officers was open to question on the grounds of improbability, given the clear indications of mental illness enumerated in the report; (ii) if the police officers did reach the conclusion that Mr Rigg was not mentally ill, it was open to question whether they were observing him carefully enough and assessing him on an on-going basis; and (iii) the omissions and/or failures of the police officers in relation to identifying Mr Rigg as a person with mental health issues were indicative of a lack of care towards Mr Rigg as a person in their custody.

The issue of race

The IPCC also pursued with PC Glasson the issue of possible mental illness in relation to Mr Rigg's behaviour in the van: "Between that restraining time there and getting to the station was there anything that gave you any concerns about his mental health?" PC Glasson's response was "Wouldn't be able to say mental health, obviously the behaviour of sitting between the chairs is unusual but then whether that's mental health or other reasons which could have been, especially with people you come across in Brixton, so we were a bit worried about his behaviour but what exactly that was attributed to at that time we wouldn't know."[205]

This response raises a number of concerns. Which other reasons, apart from mental health, are meant? Is bizarre behaviour, such as Mr Rigg was described as exhibiting, normal behaviour for "people you come across in Brixton"? What are the other reasons that might explain Mr Rigg's

[203] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 28 June 2012, transcript p.113.
[204] Coroner's Inquest, 28 June 2012, transcript p.114.
[205] IPCC interview with PC Glasson, 26 March 2009, transcript of first tape p. 23.

"unusual" behaviour? It may be that PC Glasson had some reason other than race in mind, but the question was never asked. **This needed to be pursued by the IPCC. 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.**

One of the terms of reference of the IPCC investigation was "To establish whether any acts or omissions of any police officers were motivated by the ethnicity of Sean Rigg." Therefore, race was an issue that needed to be considered by the IPCC, whether or not it then found there to be any concerns to be raised regarding racial discrimination. **The IPCC's own internal review emphasised that it had found no evidence that the interviews explored whether any acts or omissions of any police officers were motivated by the ethnicity of Mr Rigg**.

In its submission to this Review, the charity INQUEST rightly pointed out the difficult context in which the IPCC investigation into the death of Sean Rigg took place, including both previous high-profile deaths in custody involving black persons[206] and general concerns about excessive use of force.[207] Inquest made the cogent point that "The IPCC should not be afraid to identify the primary, contentious features in a case e.g. mental health, restraint and race. This is not to prejudge the investigation or with the purpose of ruling those issues in or out but to make clear the IPCC is aware of and has identified the primary concerns and issues that need to be examined. To put on public record that the IPCC recognises the important questions and issues to explore and is there to conduct a robust investigation will go some way to satisfying the public interest and concern about these deaths."[208]

The Review team has discussed these matters with the charity INQUEST and agrees that this approach should be followed in future cases.

E. Use of force

The restraint of Mr Rigg

Mr Rigg was handcuffed in the 'rear stack' position. The stack positions (front or rear) are those where the wrists pass through the cuffs in opposite directions, rather than palm to palm or back to back. In Mr Rigg's case, it appears that standard issue rigid cuffs were applied behind his back while he was being held down in the prone position on the ground.

The issues of mental health and use of restraint are interwoven in the circumstances of Mr Rigg's death in custody. It has long been recognised that the use of restraint must be adapted when the person to be restrained is suffering from mental illness. The IPCC investigation report makes specific reference to the MPS policy 'Policing Mental Health' and to the risks of restraining a person

[206] The deaths of Brian Douglas, Wayne Douglas, Ricky Bishop, and Derek Bennett.
[207] INQUEST, 'Written submission to the Casale Review', 5 February 2013.
[208] INQUEST, 'Written submission to the Casale Review', 5 February 2013.

with mental illness who resists in a violent and prolonged manner.[209] The policy requires police officers to treat all such cases as medical emergencies.[210]

The general principle is that "Officers must be able to show that the use of force was lawful, proportionate and necessary in the circumstances."[211] The guidance applicable at the time stated that "All staff should be aware of factors that heighten the risks associated with a suspect or detainee. In assessing these risks consideration should be given to a number of physical, mental and medical conditions."[212] The guidance further stated that "People who are violent and agitated pose an increased risk to the safety and welfare of others. There may be an underlying medical reason for the behavior such as a head injury, drug or alcohol misuse or a mental illness. If there is any suspicion that the violence stems from a medical condition, the person should be treated as a medical emergency. Wherever possible, the person should be contained rather than restrained until medical assistance can be obtained."[213] These are the standards against which the conduct of the police officers who arrested and restrained Mr Rigg should have been assessed.

The IPCC investigation report states that "there is no evidence to suggest that the officers knew Mr Rigg was suffering from mental health problems, therefore the policy and standard operating procedures were not appropriate to apply."[214] **The reasoning behind this statement does not bear examination.** The appropriateness of applying the policy and standard operating procedures depends on an objective test rather a subjective one: according to the ACPO and Home Office guidance, the question was whether or not the police *could reasonably have been expected to have any suspicions* that they were dealing with a person suffering from mental health problems, rather than whether the police officers *knew* that Mr Rigg was suffering from a mental illness. What happened should have been recognised as a failure by the police officers to apply the correct procedures. The explanation for that failure is that they failed to recognise the indications that Mr Rigg was suffering from mental health problems. It is difficult to conclude from the evidence available that the police intentionally ignored Mr Rigg's mental illness.

The IPCC report proceeds "notwithstanding the mental health aspect of Mr Rigg's arrest, how he was restrained still formed part of our investigation into the circumstances of his death." It then examines the issue of restraint without reference to mental health. However, it should be recalled that the guidance, applicable at the time in relation to the need for risk assessment of all detainees, states that "the assessment must be on-going".[215] Therefore, even if one were to take the view that the police officers might, in the heat of the moment of apprehension, not have immediately suspected that Mr Rigg was a person with mental health problems, this would have been expected to change with the passage of time and opportunities to assess the situation again.

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[209] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, paras 454-457. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[210] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006.
[211] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, Section 4.2
[212] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006, Section 2.4.
[213] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, Section 2.4.6.
[214] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 459. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[215] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, Section 2.1.

The ACPO and Home Office guidance also calls for one of the members of the team involved in restraining the person to take charge of the incident, ensuring that the detainee's health is monitored.[216] From the accounts given by the police officers involved, it appears that there was no clear leader of the team who would have been responsible, *inter alia*, for deciding when Mr Rigg was under control and then ordering an immediate change from the prone position. There appears to be no systematic requirement for police officers to record the use of restraint; such a requirement would assist monitoring and analysis of use of force. The Review considers this a gap in current safeguards.

Duration of restraint in the prone position

It has long been established that the physical strain generally associated with being restrained may adversely affect a person's health and that the greatest health risks are associated with persons being restrained in any position in which the chest is subject to increased pressure (e.g. as in the prone position), particularly for a prolonged period. When cuffs are applied to wrists behind the back, this increases the tension in the chest area and has an impact on breathing. The extreme, when the person stops breathing, is referred to as positional asphyxia, the dangers of which were emphasised in the guidance applicable at the time:[217] "When a detainee is restrained in a prone position for any length of time, one team member should be responsible for protecting and supporting the head and neck. That person should lead the team through the physical intervention process and ensure that the airway and breathing are not compromised and that vital signs are monitored. Prolonged restraint and struggling can, particularly when the lungs are squeezed while empty, result in exhaustion. This can be without the detainee being aware of it and can lead to sudden death."[218]

Mr Rigg was held down in the prone position with his hands cuffed behind his back. The guidance states that "The prone position should be avoided if at all possible, or the period for which it is used minimized."[219] The first of two photographs taken by a local resident using her mobile telephone shows Mr Rigg at 19.39 closely surrounded by four police officers, who are kneeling or squatting and bending over him: two are leaning over the area of his head and shoulders, and two are leaning over his upper torso. If not actually cuffed at this point, he was definitely under manual restraint. From the second photograph taken at 19.43, it is not possible to see that Mr Rigg's hands are cuffed, but this may be inferred from the fact that, by this point, only one officer is leaning over his upper body. The officer has his right arm outstretched and his right hand is over Mr Rigg's hands, behind Mr Rigg's back; another officer is lying over Mr Rigg's lower legs. A third officer is kneeling on the ground on the opposite side from his colleagues, looking at something in his own hands. A pair of white plimsolls and a small maroon item, which looks like the passport, can be seen on the ground next to Mr Rigg. The witness, who took the photographs from her flat overlooking the scene, stated that the part of the incident she saw lasted about ten minutes.[220] This duration fits with her testimony

[216] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, Section 4.3.
[217] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006, Section 4.4.
[218] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, Section 4.3.1
[219] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, Section 4.4.
[220] IPCC statement S31, p. 2, and Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 22 June 2012, transcript p. 37.

at the inquest, when she explained that at about 19.35 her friend alerted her to the fact that an incident was occurring outside the window of her flat on the Weir Estate; she "saw a man already on the ground with four police officers around him".[221] She relates that he was face down and that the officers seemed to be trying to restrain him.

The IPCC commissioned an expert to retrieve and report on the photographs stored on the mobile telephone. However, the expert failed to point out and report on the embedded information about the exact times when the photographs were taken.[222] The IPCC did not expressly request that information, but the expert should have automatically included it without a specific request. It was only at the Coroner's Inquest that this important evidence as to timing was examined. **This was a crucial omission.**

The Review recommends that steps be taken by the IPCC to ensure that competent expertise is available to IPCC investigations from a wider range of independent experts, including as regards restraint.

The MDT in police van LD2N provides further information: it shows that the van had originally drawn to a halt at the junction of Weir Road and Radbourne Road[223] at 19.37.24 and was still stationery at 19.41.53; the MDT printout indicates that the van had moved off again at some time after 19.41.53 but before 19.42.28, by which time it had reached a speed of 44 mph. The stationery period of between four and five minutes corresponds to the time when PC Birks, the only driver of the van, went to assist in restraining Mr Rigg. He then returned to the van (he is missing from the second photograph, taken at 19.43). He then drove around to park closer to the scene of Mr Rigg's arrest and restraint: the MDT shows that the van stopped again at 19.45.39, after a drive of over three minutes but under four minutes, in a position between Olding and Jewell House.[224] Apparently PC Birks was unfamiliar with the complicated access routes into the Weir Estate.[225] This timing also fits with the evidence of the witness and her photographs. This combination of sources of evidence indicate that Mr Rigg was prone and being restrained for at least eight minutes.

At the Coroner's Inquest, the exact procedures used during the restraint of Mr Rigg were examined in detail. This included questioning of PC Glasson about (i) how he applied force to Mr Rigg's back, and (ii) the bruising on Mr Rigg's left shoulder and back corresponding to the position of PC Glasson's application of force.[226] This line of inquiry was difficult, given the passage of almost four years since the events. **The Review considers that more detail regarding the restraint methods used could and should have been explored by the IPCC soon after the event.**

[221] Coroner's Inquest, 22 June 2012,, transcript p. 33.
[222] Examination of Mobile Phone, September 2008, IPCC document D153
[223] IPCC interview with PC Birks, 21 January 2009, transcript p. 3, and 18 March 2009, transcript p. 7.
[224] IPCC interview with PC Birks, 21 January 2009, transcript p. 4.
[225] The van MDT shows some mistaken turns as the driver tried to bring the van close to where his colleagues were holding Mr Rigg.
[226] Coroner's Inquest, 29 June 2012, transcript pp. 72-76.

Officer safety training

The IPCC asked Inspector Sutcliffe, the officer responsible for MPS Officer Safety Training, to comment on officer safety training regarding the restraint of violent individuals, including with regard to positional asphyxia and acute behavioural disorders.[227] As the basis for this comment, the IPCC provided Inspector Sutcliffe with précis versions of the interviews with PCs Birks, Forward and Glasson, as well as the three initial witness statements made by PC Birks, Forward and Harratt on the night of Mr Rigg's death, the photographs of the arrest and restraint scene, and the relevant CCTV footage. Since the IPCC was not aware at the time of the duration of the restraint while Mr Rigg was lying prone, Inspector Sutcliffe was not told that this lasted at least eight minutes.

In his comment, Inspector Sutcliffe emphasised the need to move the person from the prone position as soon as possible. The guidance applicable at the time stated that "There is a risk of positional asphyxia when restraining the person. The prone position should be avoided if at all possible or the period for which it is used minimised."[228] Inspector Sutcliffe distinguished between the period of control (which he considered to be depicted in the photograph showing the four officers) and the period of restraint (which he considered to be depicted in the photograph showing the three officers). Inspector Sutcliffe stated that "Once control is achieved, however, I would expect officers to work as swiftly and methodically as the circumstances allow, handcuffing the individual and getting him or her up from the prone position."[229]

The guidance applicable at the time[230] refers to the particular vulnerability to the impact of being restrained of detainees suffering from the effects of alcohol, drugs, a mental health condition, or another medical condition;[231] referring to this guidance, Inspector Sutcliffe stated that "officers are trained to monitor the person's condition and to get them onto their side, in a seated or standing position, as soon as control is achieved". In the case of Mr Rigg, this would have been from the start of the control period as shown in the second photograph. By their own accounts, it appears that the officers did not do so. PC Glasson is the only officer to refer to placing Mr Rigg on his side, whereas the other accounts refer to Mr Rigg being prone and then being assisted to stand before being taken to the police van. Witnesses to Mr Rigg's being raised to his feet and taken to the van confirm this version of events.[232]

The IPCC concluded that the investigation uncovered "no evidence to suggest that the techniques used by the officers and the level of force applied during the arrest of Mr Rigg was disproportionate or unlawful."[233] However, this conclusion does not make reference to the long duration of the restraint nor to the indicators of mental health issues – both pertinent factors in assessing the

[227] IPCC statement dated 8 September 2009, IPCC statement S128.
[228] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (second edition), 2012, p. 50. Available at http://www.homeoffice.gov.uk/publications/police/operational-policing/safer-detention-guidance?view=Binary.
[229] IPCC statement dated 8 September 2009, IPCC statement S128.
[230] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006.
[231] ACPO and Home Office, The Safer Detention & Handling of Persons in Police Custody, 2006, para. 4.1.
[232] Statements by three witnesses from the local family, IPCC statements S89, S90, and S91.
[233] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 472. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

proportionality of restraint. **In this regard, the Review notes that the Coroner stated in his summation at the inquest that it was open to the jury to find that there was what amounted to a breach of the MPS standard operating procedures or other regulation or guidance with respect to the length, position and use of force in restraint**.[234]

Retention of means of restraint

Mr Rigg remained in cuffs in the van, despite being locked in the cage throughout the journey to the police station: a journey of six minutes (from 19.49.23 to 19.55.23, according to the van MDT). The justification for not removing the cuffs in the case of a person not suffering from mental illness could be that it might be difficult and/or dangerous to gain control of the person when removing him from the van cage.

Mr Rigg remained in cuffs in the van while waiting in the police station yard for a further eight to eleven minutes: the precise period is unclear, given discrepancies in the CCTV timing. The justification for this advanced in the interviews was that the custody suite was busy and there was no room to transfer Mr Rigg there.

When PC Vanderpujie gave a statement to the IPCC in February 2009,[235] this was mainly about his presence at the custody area when Mr Rigg was brought in and his own later participation in CPR on Mr Rigg. In his evidence at the Coroner's Inquest, PC Vanderpujie described the evening of 21 August 2008 as "a relatively quiet night".[236] He also said that "there were definitely spaces free." The custody sergeant stated at the Coroner's Inquest that he asked PC Birks to keep Mr Rigg in the cage of the van because there were people in the custody suite and others were being booked in.[237]

It should be noted that there was no CCTV in the van at that time. (Happily, the MPS are now piloting the use of CCTV equipment in police vans in Lambeth. **This is a welcome attempt to improve the situation**.) If Mr Rigg had been transferred from the van to the custody suite, he would have been covered by CCTV. If Mr Rigg had been placed in a cell in the custody suite, the cuffs would have been removed and he would have been monitored by CCTV. **The decision to keep Mr Rigg in the van for eight to eleven minutes prolonged both his restraint and his exclusion from CCTV coverage.**

The IPCC did question the police officers about radioing ahead to the station to check on the availability of custody space, but did not criticise the failure to ensure that Mr Rigg was speedily booked into the custody suite.

According to PC Forward's second IPCC interview,[238] the cuffs were not removed until the FME advised bringing a blanket to keep Mr Rigg warm: this occurred at around 20.14, according to the CCTV. Therefore, Mr Rigg was under restraint from before 19.39, when the first of the witness's

[234] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 27 July 2012, transcript p. 9.
[235] IPCC statement S85.
[236] Coroner's Inquest, 17 July 2012, transcript p. 139.
[237] Coroner's Inquest, 10 July 2012, transcript p. 29.
[238] IPCC interview with PC Forward, 18 March 2009, transcript p. 27.

photographs showed him being restrained manually by four police officers in the prone position, until around 20.14.

F. Duty of care

The officers involved in apprehension, restraint, transportation and detention

In response to matters raised by the Rigg family, the IPCC concluded that "the officers adhered to policy and good practice by monitoring Mr Rigg in the back of the van whilst being transported to Brixton Police Station following his arrest".[239] At the speed registered for the van (reaching up to sixty-three miles per hour), as it sped with blue lights on back to Brixton Police Station, Mr Rigg's position in the van as described by the officers would have put him at risk, particularly as he would have been less able to protect himself from injury with his hands cuffed behind his back. The police officers made no reference to moving Mr Rigg into a safer position.

Since this is one of only two findings articulated at the end of the IPCC investigation report, the impression is created that the actions of the police officers were generally in accordance with good practice.

Every officer has a duty of care to any person in his or her custody.[240] This applies to the four officers who apprehended and restrained Mr Rigg and then transported him back to the police station, where they were present at his collapse. **The Review considers that there is an accumulation of evidence from the IPCC investigation and the Coroner's Inquest that warrants the IPCC revisiting the matter of the four officers' duty of care. In particular, the Review recommends that the IPCC look again at whether the officers (i) moved Mr Rigg promptly from restraint in the prone position and assessed him adequately, as soon as he was brought under control, (ii) ignored clear signs that he was mentally unwell, (iii) took steps to ensure his safety and well-being during the time when he was locked inside the van cage and** situated in the footwell, **cuffed in the rear stack restraint position, and (iv) provided him with prompt access to medical attention.**

The custody officer

The role of the custody officer is governed by the Police and Criminal Evidence Act (PACE):[241] the custody officer has a duty of care both to persons arriving for placement in the custody suite and to all detainees held there. At the Coroner's Inquest, Sergeant White, one of the two custody sergeants on duty when Mr Rigg arrived in the van, explained the booking in procedures to be carried out by

[239] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para 641. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[240] This duty results from the imposition of the standards set down for arresting and detaining persons within the Codes of Practice issued pursuant to the Police and Criminal Evidence Act 1984 and the training by the MPS in this area..
[241] Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers, Police and Criminal Evidence Act 1984, February 2008 (revised May 2012), Section 39.1. Available at http://www.official-documents.gov.uk/document/other/9780108511691/9780108511691.pdf (May 2012 version).

the custody sergeant when a detainee arrives; these include asking the person whether he or she needs care. Sergeant White confirmed that most of the information generally comes from the accompanying officer(s), but any contradiction by the detainee of that information has to be recorded on the custody record.[242]

In his first IPCC interview, Sergeant White said that, when he came on duty before 19.00, the custody suite was "not too busy".[243] At the Coroner's Inquest, he remembered the van LD2N calling in to ask whether there was space and his response that there was space (meaning a cell free in the custody suite).[244] He further stated that when Mr Rigg arrived at the police station he was kept in the van because there were people in the custody suite and others being booked in.[245]

At the Coroner's Inquest, Sergeant White confirmed that, according to PACE, detainees are the custody sergeant's responsibility, even when they have not yet been booked in and remain in a van on the police station premises.[246] It is clear to the Review that the custody sergeant's duty of care towards Mr Rigg began from the moment that the van carrying Mr Rigg arrived at the police station, regardless of whether or not Mr Rigg was booked into the custody suite.

In his IPCC interview in March 2009, Sergeant White stated that he went out to the van and checked on Mr Rigg.[247] The IPCC investigation report's chronicle of what happened on the evening of 21 August frequently attributes events to the relevant witness; as regards the sergeant's visit to the van, this is reported as an event without attribution, although it could be inferred from the context that this action was alleged in PS White's statements to the IPCC.

In his second IPCC interview, PC Harratt said that the "section skipper" came out to the van; he confirmed, on questioning, that Sergeant White did so too.[248]

The discrepancies in the CCTV timings and the non-functioning cameras complicated the task of the IPCC investigators. The first IPCC compilation of CCTV footage from the police station omitted a crucial period when Mr Rigg was moved from the van in the police station yard to the 'cage' in the custody area.[249] The Rigg family devoted a great deal of time to painstakingly viewing all the available original footage. By doing this, they succeeded in establishing the truth about what happened in a way that the IPCC, with its limited resources and pressures to prioritise tasks, did not. **The Review considers it regrettable that the IPCC was not able to deduce from the CCTV**

[242] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 10 July 2012. transcript p. 13.
[243] IPCC interview with Sergeant White, 20 March 2009, transcript p. 7. The Brixton police station custody suite had a capacity of ten cells for male detainees and a separate section with three cells for female detainees. IPCC interview with Sergeant White, 20 March 2009, transcript p. 32.
[244] Coroner's Inquest, 10 July 2012, transcript pp. 21-22.
[245] Coroner's Inquest, 10 July 2012, transcript p. 29.
[246] Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers, Police and Criminal Evidence Act 1984, February 2008 (revised May 2012), Section 2.1A. Available at http://www.official-documents.gov.uk/document/other/9780108511691/9780108511691.pdf (May 2012 version).
[247] Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers, Section 2.1A.
[248] IPCC interview with PC Harratt, 26 March 2009, transcript p. 27. PC Forward confirmed in his second IPCC interview that another officer, whose name he did not know, came out to the van. IPCC interview with PC Forward, 18 March 2009, transcript of second tape p. 2.
[249] A revised compilation including footage of the transfer of Mr Rigg from the van to the 'cage' was later submitted as evidence for the Coroner's Inquest.

footage that the custody sergeant was lying about visiting Mr Rigg in the van. One of the most important facts established beyond any doubt by the Rigg family's determined efforts was that the police station CCTV footage shows that Sergeant White did not exit the custody area, did not go out to the van, and did not see Mr Rigg there.

At the Coroner's Inquest, examination of the CCTV footage from Brixton Police Station established that Sergeant White did not go out to the van at all, although he described this in some detail in his IPCC interview and initially at the Coroner's Inquest. The IPCC is in the process of conducting a separate investigation into the consistency of the evidence given by Sergeant White and PC Harratt to both the IPCC and the Coroner's Inquest. At the time of writing, the Review notes that IPCC investigators have arrested two serving police officers and one retired police officer.[250]

There was early evidence to indicate that Mr Rigg's state of health was poor from early in his time in the custody corridor. PC Brown gave a two-page initial statement on the night of Mr Rigg's death.[251] She arrived at Brixton Police Station at 20.00. After a few minutes, she was asked by the custody sergeant to move further down the corridor with her detainee as a violent prisoner was about to be brought in. This fits with the timeline: Mr Rigg was brought in from the van at 20.03. While PC Brown waited "a few more minutes", she heard an officer from the 'cage' shout loudly for a sergeant to come as a prisoner was fitting. This also agrees with the timeline, which has Sergeant White going to the 'cage' around 20.06. The audio recording of voices in the custody corridor reveals the subsequent remarks: "Can we clear the decks? This bloke is either fitting, we have to get him in an ambulance, or he's very good at fitting. The doctor's looking at him. He has been very violent outside, and now he's feigning unconsciousness and fitting."[252] The custody sergeant originally denied saying this in his first IPCC interview, but later agreed, in his second IPCC interview, that these were his words. He also agreed that, whether or not the fitting was real or feigned, it had to be treated as real in terms of risk and recognised as requiring medical attention.[253]

The Review considers that the four officers who were present during Mr Rigg's arrest, restraint, detention, and transportation continued to owe a duty of care to Mr Rigg pending his transfer to the custody cells. From the viewpoint of the Review, it is important that there was, in fact, no visit to the van to assess Mr Rigg, either as to the risks he presented to others or as to his condition and care needs. **This represents an omission in relation to the officers' duty of care.** (The Review notes that a visit to the van was made by Inspector Dunn, who had been told about Mr Rigg's assault on PC Forward and was therefore checking on PC Forward's condition and whether or not he required medical attention. Sergeant Dunn stated that he did not notice what was happening with Mr Rigg in the van as his attention was on PC Forward.[254])

As to the level of attention owed to Mr Rigg, the custody sergeant described the process of assessment applying to detainees who are brought in for booking into custody at the police station:

[250] Two were arrested on suspicion of perjury and perverting the course of justice, and one on suspicion of perverting the course of justice; all three were arrested on 27 March 2013 and bailed until May 2013.
[251] Statement of PC Brown, dated 21 August 2008, IPCC statement S11.
[252] IPCC interviews with Sergeant White, 26 March 2009, transcript p. 6.
[253] IPCC interviews with Sergeant White, 20 March 2009, transcript p. 58, and 26 March 2009, transcript p. 6.
[254] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 187. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

"All I'm looking at is seeing how the prisoner is and speak [*sic*] to the officers to judge whether I can bring him into the custody suite straightaway, take him to the cell or, and prioritise [*sic*] him."[255] In fact, by Sergeant White's own admission to the IPCC investigator, he was not able to satisfy himself that Mr Rigg was fully conscious and fully fit and well, since he could only do this through in-depth questioning, such as would occur at the custody desk when booking a person into custody. When the IPCC interviewer asked Sergeant White what issues he might have considered in connection with the uncertainty as to whether Mr Rigg was fully conscious and fully fit and well, he replied "Mental health is a possibility, but so is drink and drugs."[256]

Sergeant White stated that he had not been informed about the restraint of Mr Rigg. This is contrary to applicable guidance: "As soon as possible after arriving at the police station the escorting staff must inform the custody officer about any restraint techniques used. The custody officer must, where practicable, ascertain the extent of any injury and consider whether there is a need for medical attention."[257] Nor had Sergeant White been told about Mr Rigg's reported 'spinning' with his legs up while lying in the footwell of the van's cage. The Review considers that, if this testimony about communications to the custody sergeant concerning Mr Rigg is true, this evidence of poor communications could amount to a lack of care for the wellbeing of Mr Rigg, especially given all the indications of mental health issues.

Police response to Mr Rigg's failing physical health

After about eleven minutes waiting in the van, Mr Rigg was moved to the holding 'cage' by the entrance to the custody area. The configuration of this part of the police station premises in 2008 left much to be desired: the 'cage' area was a cramped space measuring 3.64m^2, as compared with a minimum of 8.05m^2 in the detention cells,[258] and was subject to movements to and from the yard. As a place to hold someone in Mr Rigg's condition, it was wholly inappropriate. The Review understands that refurbishment of Brixton Police Station has been underway for some time and that this includes improvements to the custody area.

The transfer of Mr Rigg to the 'cage' occurred between 20.02.30 and 20.03.53, according to the CCTV cameras in the yard and in the custody corridor; he was still cuffed with his hands behind his back and was now being moved slowly and awkwardly with police officer assistance. The poor quality of the CCTV images makes it hard to be certain of Mr Rigg's state of health at that time, but after he arrived in the 'cage' he appeared to be seated in a slumped position on the concrete floor. Even then Mr Rigg was not booked in, nor was he the subject of a proper risk assessment by the custody sergeant. Sergeant White stated at the Coroner's Inquest that he decided to accept the officers' account that Mr Rigg was potentially violent and had no care needs, postponing his own assessment until he could book Mr Rigg into custody – an eventuality that never took place.

[255] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 10 July 2012, transcript p. 313.
[256] IPCC interview with Sergeant White, 20 March 2009, transcript p. 45.
[257] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006, p. 51.
[258] The Review is grateful to the MPS for providing information about the cage area and the refurbishment programme, as well as for facilitating the Review's examination of a police van identical to that used to transport Mr Rigg.

The duration of Mr Rigg's restraint in cuffs in the rear stack position was in excess of 31 minutes, starting at an unknown time after 19.37 (when the van pulled up at the Weir Estate for the officers to give chase) but before 19.39 (when the photograph taken on a witness's mobile phone shows Mr Rigg prone and already being restrained) until after he collapsed in the 'cage' holding area in the police station at 20.10.17 hours.[259] The custody sergeant stated in his first IPCC interview that he stipulated removal of the cuffs when he saw Mr Rigg "lying face-down with his hands cuffed to the rear";[260] he explained that this "would relieve the pressure on his chest to prevent asphyxiation."[261]

Responsibility for the use of force rests with the police officer exercising that force. Officers must be able to show that their use of force was lawful, proportionate, and necessary in the circumstances.[262] **It is a matter of grave concern that the police continued the restraint for so long. The Review recommends that, in all IPCC investigations of deaths in custody involving restraint, the precise justification for the restraint, and its nature and duration, are addressed robustly. This would include dynamically assessing the initial and continuing need for restraint.**

Monitoring Mr Rigg's condition at the police station

The CCTV covering parts of the custody corridor showed several police officers standing in or near the 'cage', where Mr Rigg was being held, but it does not reveal close monitoring by them. The officers can be seen standing up, rather than bending down or kneeling beside Mr Rigg. In the period of about eight minutes from 20.03 hours, when Mr Rigg was shown on CCTV being moved from the van to the 'cage', until 20.10.17, when Mr Rigg appeared to be moved to a standing position, it would appear that Mr Rigg was not being monitored carefully and closely. At various times his legs can be seen on the CCTV images through the barrier formed by the standing police officers; the position of his legs varies over the period, but Mr Rigg appears to be on the floor rather than standing or sitting on seating.

During this period, the police officers failed promptly to identify and act on the deterioration in Mr Rigg's health. It is possible that this deterioration had already begun while Mr Rigg was held for about eleven minutes in the van in the police station yard. During that period he did not receive attention from a medical professional or a risk assessment. The FME first visited Mr Rigg in the holding area in the custody corridor at the police officers' request.

PC Glasson stated in his second IPCC interview that the FME "had been asked mainly because we was a little bit worried about his [Mr Rigg's] behaviour. Eventually the doctor comes out two or three times at our request."[263] The Review notes that the IPCC's analytical mapping chart of events includes references to PC Brown hearing an officer in the cage shout for the sergeant because the prisoner was fitting: this occurred shortly after 20.03 hours, when Mr Rigg was brought into the 'cage'. The matter was not pursued in the investigation. In his IPCC interview, Sergeant White

[259] According to the CCTV timing.
[260] IPCC interview with Sergeant White, 20 March 2009, transcript p. 16.
[261] IPCC interview with Sergeant White, 20 March 2009, transcript p. 59.
[262] ACPO and Home Office, Guidance: The Safer Detention & Handling of Persons in Police Custody (first edition), 2006, Section 2.4.
[263] IPCC interview with PC Glasson, 26 March 2009, transcript of first tape p.32.

described how he tried to check Mr Rigg's condition (he was cold to the touch) and to test his responses (by shouting and putting his "thumb into his [Mr Rigg's] mandibular angle"); he considered Mr Rigg's lack of response "highly unusual".[264] The IPCC did not question this use of a compliance enforcement technique as a test for responsiveness.

At 20.10.17, after Mr Rigg appeared on the CCTV to be moved to a standing position, he was reported as loosing bladder control (according to several police officer accounts); he was shown on CCTV crumpling to the floor. It is not possible to verify exactly when Mr Rigg lost bladder control, but his collapse is partially visible from the CCTV footage.

Medical care

In the first interview with Sergeant White, the IPCC interviewer asked about his awareness of Mr Rigg's mental health issues. When Sergeant White initially stated that he only learnt of this some months later, the interviewer drew attention to the reference to "mental health issues" on the ambulance CAD.[265] The declaration by all the police officers that they were unaware of Mr Rigg's identity and mental health problems was never properly explained in light of the inclusion of that information on the ambulance CAD.

The police officers give varying accounts about the FME visiting Mr Rigg in the holding area. The CCTV shows the FME arriving at 20.13 and going into the 'cage', where Mr Rigg was on the floor. The FME told the IPCC that he checked on Mr Rigg at the request of one of the police officers, who thought that the "man who is in the cage doesn't look alright."[266] The FME described Mr Rigg as "lying down on the floor, he was breathing, the right side of the face on the floor. 18 beats per minute, checked pupils, pulse 90, volume was good but fast heart sounds. Body warm, but not communicating, loss of bladder because his trousers were wet."[267]

The FME stated that he told the custody sergeant to call an ambulance immediately. At the time he suspected a heart attack or excited delirium.[268] He requested that a blanket be brought for Mr Rigg. At 20.15, an officer is shown on the CCTV bringing a blanket. The FME stated that, having returned to his room to write up his notes, he was recalled after three to five minutes by the sergeant shouting that the man had stopped breathing.[269] **It is hard to understand why the FME went away from a man in Mr Rigg's condition to write up his notes while an ambulance was awaited.**

According to his statement to the IPCC, having returned, the FME checked Mr Rigg and found no chest movement. His notes record that an officer was performing CPR, that others came to assist, and that a defibrillator was brought. At 20.25, an officer is seen on the CCTV footage hurrying from the 'cage' and through the custody corridor; shortly thereafter, he is seen to return with a defibrillator. It is clear from the FME's statement and officers' accounts that the FME was observing

[264] IPCC interview with Sergeant White, 20 March 2009, transcript p. 18.
[265] IPCC interview with Sergeant White, 20 March 2009, transcript p. 70.
[266] Statement taken on 15 September 2008, IPCC handwritten document D110.
[267] IPCC handwritten document D110, pp. 7-8.
[268] IPCC handwritten document D110, p. 9.
[269] IPCC handwritten document D110, p. 10.

rather than leading these efforts. The CCTV footage confirms this, as the FME is clearly seen hovering in the custody corridor and moving back and forth on the fringes of the CPR activity. The Review considers that, in such circumstances, it is incumbent upon the FME to oversee the use of CPR and the defibrillator.

The arrival of the first ambulance crew is timed on CCTV as occurring at 20.36.24: the second crew's arrival is shown at 20.43.32. A stretcher is seen being brought in at 20.58. Mr Rigg is seen being placed on the stretcher with an intravenous drip at 20.59. The CCTV in the Brixton Police Station yard shows the ambulance leaving for the hospital at 21.03.

The emergency treatment provided to Mr Rigg is difficult to see on the CCTV footage as the 'cage' is blocked by the backs of various police officers. The ambulance staff reportedly considered the officers had done a good job of trying to resuscitate Mr Rigg. The IPCC's conclusion that the police officers complied with good practice when monitoring Mr Rigg in the police van[270] might be more appropriately applied in respect of their efforts at providing emergency care to Mr Rigg when it finally became clear to them that he was in crisis.

The FME's actions drew strong criticism in the Commissioner's Foreword to the IPCC investigation report: "it was 11 minutes before Mr Rigg was taken to the caged custody area from the van. After his collapse in that area, we were so concerned about the action (or inaction) of the forensic medical examiner (FME) that we reported him to the General Medical Council (GMC). He resigned shortly afterwards." This forthright statement of concern is at odds with the guarded tone of the criticism in the report itself. The presence of the FME did not result in immediate access to medical assessment or care and, when the FME did become involved with Mr Rigg's situation, his assessments and actions did not correspond to the unfolding crisis. As the deterioration in Mr Rigg's health became acute, the police officers, while not absolved of their responsibility for his care, would understandably have felt that the responsibility was shared with both the medical professional at the station and the custody sergeant.

The FME is seen on CCTV to hover on the fringes of the emergency and only rarely to insert himself through the virtual cordon of police officers around Mr Rigg in order to take a closer look at him. The Review does not intend to go over all the details collected by the IPCC about the FME's actions. **In the absence of a judgment by the GMC, the IPCC would have been justified in considering that the FME had failed in his duty of care,** but may have decided to refrain from spelling this out in the investigation report because the FME had already taken early retirement.

The Review notes that there have been considerable advances in the training of forensic doctors working in police settings, in particular through programmes developed by the Faculty of Forensic and Legal Medicine (FFLM) of the Royal College of Physicians of London. These programmes are aimed at developing and maintaining "the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity".[271] The programmes include *pro forma* relating to forensic medical examinations, fitness for detention and interview, MHA

[270] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 641. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.
[271] FFLM of the Royal College of Physicians of London, FFLM Training Standards and Policy, 2010 (revised 2013). Available at http://fflm.ac.uk/upload/documents/1358340451.pdf (2013 version).

assessment, and forensic notes relevant to sudden death. The Review welcomes the FFLM's development of (i) quality standards in forensic medicine for doctors, (ii) custody officer training, (iii) practical induction training in clinical forensic medicine, and (iv) guidelines on the management of acute behavioural disturbance in police custody. The Review also welcomes the British Medical Association's guidance on health care of detainees in police stations.[272]

Cause of death and forensic evidence of ill-treatment

The results of two post-mortems, the first carried out by the Home Office pathologist shortly after Mr Rigg's death, and the second commissioned by the Rigg family, were available to the IPCC investigation and informed its development. As often occurs in post-mortem examinations, the medical cause of death was unascertained. They both found no evidence of intoxification or trauma to the brain.

The first post-mortem noted no evidence of structural abnormality or occult natural disease. It speculated as to the role of certain factors in Mr Rigg's death: the circumstances surrounding his death were physiologically stressful, triggering release of adrenalin. There may have been an underlying abnormality of heart rhythm and subsequent cardiac arrest, whether due to his paranoid schizophrenia and its treatment, or to an underlying and undetected channelopathy of the heart. This post-mortem found no evidence that Mr Rigg's death related to the direct effects of positional asphyxia during restraint.

The second post-mortem found early ischaemia in the brain, common in deaths from both natural and unnatural causes. Examination of the heart did not rule out that Mr Rigg could have died of cardiac arrhythmia (noting the association between schizophrenia and psychotropic drugs in sudden adult death and that psychotropic drugs cause prolonged Q-T on the electro encephalogram, leading to cardiac arrhythmias and sudden death), especially during a state of high excitement with increased catecholamine rush and increased motor activity requiring greater oxygen, which may not have been forthcoming under restraint. The second post-mortem reported no evidence of asphyxia.

The opinion of the IPCC's medical expert concluded as follows: "On the balance of probabilities the circumstances surrounding the arrest and custody have to be causal to the death." However, the medical expert commissioned by the Rigg family concluded that there was no evidence to indicate that restraint, during arrest or subsequently, played a *direct* part in Mr Rigg's death. He considered that Mr Rigg died from an acute psychotic episode; he noted that there is a significantly increased risk (two to three times above normal) of sudden collapse and death in patients suffering from schizophrenia and that such events may be triggered by an acute psychotic episode, such as in this case.

At the Coroner's Inquest, the causes of death were given as "cardiac arrest, acute arrhythmia, ischemia and partial positional asphyxia"; the narrative verdict of the jury stated that the duration of the restraint contributed more than minimally to the death of Sean Rigg.[273]

[272] The review is indebted to Dr Peter Green of the FFLM for providing information and advice on these developments.
[273] Inquisition at Southwark Coroner's Court, Jury's narrative verdict, 1 August 2012. Available at http://www.gardencourtchambers.co.uk/imageUpload/File/Inquisition-for-Mr-Rigg.pdf.

In his summation, the Coroner ruled that it would not be safe for the jury to find unlawful killing on the evidence cited[274]and also ruled out both a verdict of neglect by SLaM and by the MPS. [275] On the Coroner's advice, the jury considered whether there were defects in the system that contributed to the death, whether there were any other factors relevant to the circumstances of death, and whether these contributed more than minimally or negligibly or trivially to Mr Rigg's death, based on the balance of probabilities.

The jury found, *inter alia*, a series of failures in the care provided to Mr Rigg by the SLaM clinical team and/or at the Penrose Hostel, and also inadequacies in communications, assessment and crisis planning. As regards the police, the jury found a lack of sufficient and effective communication within the police, an unsuitable level of force used during restraint, a lack of leadership leading to failure to take effective control of the arrest and restraint situation, and an unnecessary length of restraint in the prone position. The majority view of the jury was that the length of restraint in the prone position more than minimally contributed to Mr Rigg's death. The jury's view concerning its finding that Mr Rigg had suffered partial positional asphyxia related to its determination that restraint in the prone position had lasted at least eight minutes.

The jury's narrative verdict also identified a failure by the police to identify Mr Rigg as a vulnerable person at the point of arrest, a lack of care while he was inside the van at the police station, a lack of assessment of his physical and mental condition by the police, a failure to follow the standard operating procedure relating to mental health, and unnecessary and inappropriate retention of restraint. The jury found that an absence of appropriate care and urgency of response by the police when he was in the 'cage' of the police station more than minimally contributed to Mr Rigg's death.

The IPCC investigation report considered the use of force, including the restraint of Mr Rigg, to have been necessary and proportionate and, thus, that there was no basis for considering that the police officers contributed to his death. **However, in light of the evidence that emerged at the inquest, the Review considers that the duration of the restraint in the prone position appears to have been prolonged beyond the threshold of what could be regarded as necessary, proportionate and reasonable. In turn, this may have an impact on the question of the police officers' contribution to the death of Mr Rigg.**

As regards the use of force, the two post-mortems were in agreement in concluding that the injuries found (i.e. bruising, grazes, and marks of cuffs) were not unusual in the circumstances and did not indicate substantial trauma to the body by a third party. The rib fractures found were reported to be typical of resuscitation activities. The IPPC investigation report drew the conclusion[276] that the post-mortem results show "no evidence of any kind of assault having been perpetrated against Mr Rigg". It would be more accurate to conclude that no evidence of substantial trauma was found. It is often the case that ill-treatment not rising to the level of substantial trauma goes undetected because it may leave no clear marks that cannot be explained in other ways. **The Review considers that the absence both of physical signs of trauma attributable to assault, and of credible witness**

[274] Inquisition at Southwark Coroner's Court (Coroner's Inquest), 11 June-1 August 2012, 27 July 2012, transcript p.4.
[275] Coroner's Inquest, 27 July 2012, transcript p.6.
[276] IPCC, IPCC investigation report Sean Rigg, 15 August 2012, para. 488. Available via http://www.ipcc.gov.uk/en/Pages/inv_reports_london_se_region.aspx.

testimony to that effect, effectively ruled out a finding of assault and that the IPCC was right to conclude that it would not be fruitful to pursue criminal proceedings on that basis.

IV. The IPCC and the Rigg family

Approach

It is recognised in law that the next of kin of the victim of a death in custody must be involved in the investigation procedure to the extent necessary to safeguard his or her legitimate interests.[277] The perspective of the family is obviously not impartial and, thus, is necessarily different from that of the IPCC. The Review considers that the family are fellow travellers in the search for the truth. The perspective of the family must be recognised as important. This Review has benefited significantly from the input of members of the Rigg family and their solicitors.

The IPCC records contain a list of documents received from the MPS on 1 September 2008. The Review was concerned to find that the document list for the IPCC investigation contains an early listing of PNC records for two members of Mr Rigg's family.[278] The Review has not viewed the content of these documents, but questions why they exist in the IPCC document list. Whereas the document list shows that the IPCC was immediately provided with the PNC record of Mr Rigg himself,[279] and that the IPCC requested the MPS to provide the PNC records relating to the main witnesses to the arrest,[280] there are no recorded requests from the IPCC for PNC records relating to any members of the Rigg family. No member of the Rigg family was witness to the events leading Mr Rigg's death. The Review discovered that the two documents had been included in a set of eighteen items received on 1 September 2008 by the IPCC senior investigator.[281]

Further examination of IPCC records showed that the senior investigator viewed the PNC records of the two members of the Rigg family in the context of a risk assessment related to the family's viewing of the Brixton Police Station CCTV:[282] the investigator concluded that the main risk might be an emotional reaction from members of the Rigg family, which "should be containable within the press room." On the information available to it, the Review considers that it was not necessary or proportionate for the senior investigator to view the contents of the PNC records of members of the Rigg family in this context. Data held on the PNC will almost invariably amount to sensitive personal data.[283] The Review fails to see the relevance of processing the sensitive personal data of members of the Rigg family; such processing may have been in breach of data processing principles.

After the death of Mr Rigg, his family should have been considered as akin to victims – as should the family of any person who dies in custody, unless the family is involved in the events leading to the death. **In order to avoid unjustified provision of confidential information from the MPS to**

[277] Lord Bingham's judgment in the death in custody case *R (Amin) v. Home Secretary* [2004] 1 AC 653, para 20, referring to *Jordan v. The United Kingdom* [2001] 37 EHRR 52, para. 1090. For further information see, respectively, http://www.1cor.com/1315/?form_1155 replyids=486 and available at http://www humanrights.is/the-human-rights-project/humanrightscasesandmaterials/cases/regionalcases/europeancourtofhumanrights/nr/538.
[278] IPCC documents D65 and D68, listed on 3 September 2008.
[279] IPCC document D33, listed on 21 August 2008.
[280] PNC records were requested by the IPCC for the witnesses to the arrest and restraint of Mr Rigg. See IPCC document D55.
[281] An itemised list is contained in IPCC document D59.
[282] IPCC document D56.
[283] Data Protection Act 1998, Section 2. Available at http://www.legislation.gov.uk/ukpga/1998/29/contents.

the IPCC, any such material sent to the IPCC should be sent back with a request for an explanation of why it was sent and a clear indication that the IPCC considers it inappropriate to receive such information.

Access to information

The Rigg family were determined to see that a thorough investigation took place. Their considerable and sustained efforts resulted in the emergence of information that might otherwise not have seen the light of day. The Rigg family are to be commended for their tenacity and commitment in this regard.

Upon occasion the Rigg family's requests via their solicitors for access to information did not meet with immediate success. At times they had to resort to applications under the Freedom of Information Act.[284] For example, they were not immediately granted access to Mr Rigg's medical records. In his handwritten notes, the senior investigator recorded on 24 October 2008 that "medical evidence will be referred to Coroner. Reason – family has refused to sign medical consent form unless all medical evidence is released to their solicitors. I am not willing to release such evidence."[285] **The Review considers that the family of a person who has died in custody is entitled to access to all relevant information. This should be the default position and any exceptions should only be made for compelling reasons.**

Family liaison

The initial contact with a bereaved family will almost certainly be traumatic for the family. Communicating the news of the death of a relative requires considerable skill and empathy. In the event of deaths in custody, relatives' perceptions of the roles of police Family Liaison Officers (FLOs) and IPCC Family Liaison Managers (FLMs) are likely to be blurred, as the family reacts to tragic news from strangers representing officialdom. Providing appropriate family liaison can be time-consuming and stressful.

The family of a person who dies in custody must be expected to be in shock. This will make all communications difficult; people in shock may be expected to have problems understanding and recalling what is said during the first period of loss. There is an important need for information to be given repeatedly, in different forms, and in a sensitive manner. Staff in the IPCC, as in the MPS, would benefit both from careful selection of individuals to fulfil the FLM and FLO roles and from special training, including in awareness of reactions to trauma, bereavement, and the stages of grief.

The records show a series of communications between the FLM and the Rigg family. The paperwork involved is considerable in quantity: it would seem that the problems related rather to quality. Certain key problems appear to have contributed to the deteriorating relations between the family and the IPCC. The initial press release issued on the day after Mr Rigg's death reported him as dying at the hospital, whereas it would have been more correct to report that Mr Rigg was pronounced

[284] Freedom of Information Act 2000. Available at http://www.legislation.gov.uk/ukpga/2000/36/contents.
[285] Handwritten workbook of senior investigator, annotated 30610, logged 24 October 2008.

dead soon after arrival by ambulance at the hospital. The Commissioner subsequently apologised for this. The issue of access to information for the family has already been referred to and this too may have played its part in alienating Mr Rigg's family. Both these issues are likely to arise in many cases of death in custody. The Review recommends that standard practice is agreed and followed in such matters. The presumption should be that the press release about a death in custody should, in the absence of firm information, err on the side of caution: whenever possible, it should be agreed with the family or their representative.

Contact with the Commissioner

At a meeting with the Commissioner and members of the IPCC staff in January 2009, the Rigg family complained that this was the first opportunity they had been given to meet the Commissioner. The Commissioner told the Rigg family that she had offered to meet them earlier. No date was specified and there is no IPCC record on this matter. **It should be standard practice for the Commissioner to invite the family to meet with him or her soon after the death in custody. The invitation, if conveyed orally, should also be repeated in writing. If the family feels unable to meet in the immediate period after the death in custody, the invitation should be reiterated in writing at intervals to ensure that the family has, and is aware of, the opportunity to meet with the Commissioner as soon as the family wishes to do so.**

The Commissioner was not included in many of the decisions taken during the early stages of the investigation. The 'policy book' in which the senior investigator recorded key points and decisions lists him by name at the top, but there is no listing of the Commissioner, whose name first appears on the 'policy book' completed by the new senior investigator, who took over in late January 2009. In this case, the Commissioner was the only person directly involved in the case who was not based at the IPCC London office. The Commissioner was asked to oversee this case, reportedly due to pressure on London Commissioners at the time. Normal IPCC practice appears to be for Commissioners to oversee investigations in their own region.

Today, the investigation into the death of Sean Rigg would be designated as a Critical Incident under recent policy and practice guidelines.[286] It is to be hoped that all Critical Incidents are overseen by Commissioners who are in the region and able to exert the level of scrutiny necessary to provide the further guarantee of independence intended in the legislation.

[286] IPCC, Commissioner role in independent investigations, February 2013. Available at http://www.ipcc.gov.uk/Commission documents/Item 14 - Commissioner Role in Independent Investigations [NPM].PDF.

V. IPCC methodology and means

The immediate response

The Review has already discussed the critical importance of the period immediately following a death in custody (see *The 'Golden Hour'*). The Review concludes that the initial errors and omissions at the outset adversely affected the subsequent investigation. In particular, the on-call team's weak position *vis à vis* the police and the DPS, and their reliance on them for crime scene expertise and key functions, was prejudicial to a robust and independent investigation. In part this is a matter of resources, but it is also a matter of approach. There is a clear need for an expert IPCC team to be involved at the outset, as the Home Affairs Committee concluded: "A major obstacle was the IPCC's access to specialists who could analyse a possible crime scene. Inquest [the charity] suggested that the Commission should have a panel of independent experts, rather than rely on police investigators and that investigators should be cautious about including untested police versions of events in their instructions and take note of new developments. The Police Action Lawyers Group and Inquest believed that there should be an IPCC team to attend scenes of death very quickly following police contact in order to take control of the scene and begin the process of gathering evidence. Securing evidence quickly and independently is vital in these cases to provide the public with assurance that justice is done."[287]

The Review reiterates its recommendation that detailed protocols be developed with all police services. These should spell out the duty of the DPS, in the absence of the IPCC, to safeguard the public interest concerning deaths in custody: the IPCC is not present from the outset and must rely on the police, who are on the spot and whose full cooperation they have a right to expect. It is important that the IPCC take control as soon as possible.

The Review understands that IPCC developments since 2008 have included the introduction of a new post-incident procedure. This has reportedly enabled the IPCC both to maintain better control at an early stage and to make clear its expectations concerning securing of evidence, including obtaining initial statements from police officers and securing the scene.

Overseeing the investigation

All members of the IPCC need to ensure the independence of their work and that of the organisation as a whole. According to the legislative framework, the ultimate guarantors of independence are the Commissioners. Systemic change is needed to ensure that they can exercise their duty of oversight in practice.

It is for the IPCC Commissioner overseeing an investigation to sign off on the report; therefore, it is the Commissioner who is ultimately responsible for the report as a whole. The Review notes that the Commissioner in charge of the investigation into the death of Mr Rigg was the only member of the

[287] Home Affairs Committee, Eleventh report: IPCC, 29 January 2013, para.21. Available at http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/49402.htm.

IPCC team on the case who was not located in London;[288] this had implications for the ease of effective oversight. While not participating in investigations, Commissioners must oversee them and this means ensuring that investigations are properly managed by senior IPCC staff. It would appear that in 2008 there was no clear expectation that the senior investigator manage the quality of the investigation and the analysis. If investigations were more rigorously managed, this would facilitate the Commissioners' role in ensuring a strategic and analytical approach to addressing key issues. The Review believes that this requires a more 'hands on' approach from Commissioners and more systematic and robust management by senior staff than was the norm in 2008.

In 2008 there was, if the investigation into the death of Sean Rigg is any guide, a lack of consistent understanding across the IPCC about the roles of the lead investigator, senior management, and the Commissioner in charge of overseeing the investigation; in the evolving organisational structure of the IPCC, there was a lack of clarity and coherence as regards both the respective roles of and the relation between the investigators, senior investigators, senior management, legal advisers, and Commissioners. This can be seen from a number of examples of how important decisions were taken, during the early investigation, apparently without sufficient senior management support and/or contact with the Commissioner, including on such pivotal matters as the status of the arresting police officers (e.g. whether they were to be regarded as witnesses, special witnesses or suspects) and the timing of interviews. These issues are of such obvious strategic importance that is hard to understand how consultation was not automatic. It appears that, in the absence of consultation, the Commissioner did not take a proactive stance on these matters.

The Review understands that developments in this direction are already underway and some significant changes have been effected. It is a welcome sign of progress that new guidance concerning the role of the Commissioner has been agreed[289] that clearly reflects the legislative intent as regards the role of Commissioners. The new guidance articulates that, although the Commissioner does not have an operational role, he or she must provide clear direction and scrutiny at a strategic level in order to retain overall accountability: "At all times a commissioner must scrutinise all information provided and constructively challenge, where necessary, the validity of data, decisions made or the detail, findings and conclusions of draft reports."[290]

The new guidance provides for an updated IPCC delegation scheme and specific arrangements in all Critical Incidents, including the establishment of a Critical Incident Management Team (CIMT). It is clear that the death of Sean Rigg would have qualified as a Critical Incident meriting the establishment of a CIMT. **This too is a welcome development.**

If the report on the investigation into the death of Mr Rigg were being drafted today, the Review considers that the Commissioner should be expected both to oversee analysis of the information gathered by the investigating team and to work with senior managers to develop a set of more robust findings and conclusions, indicating the major concerns to be addressed by the Coroner. These

[288] At the time, London cases were at times allocated to Commissioners outside London. This practice changed in 2009 when London cases were allocated only to a core team of south-east based Commissioners.
[289] IPCC, Commissioner role in independent investigations, February 2013. Available at http://www.ipcc.gov.uk/Commission documents/Item 14 - Commissioner Role in Independent Investigations [NPM].PDF.
[290] IPCC, Commissioner role in independent investigations.

concerns might have included possible lapses in the duty of care by those providing care in the community and by the police, as well as the need for improved arrangements to ensure cross-agency co-operation in the event of relapse on the part of individuals with mental health problems, especially those with a history of offending. The Review considers that the IPCC would have been within its remit to identify implications (i) for improved communications between agencies, as well as within the police, (ii) for police training, and (iii) for more detailed standards as regards recognising and responding to people with mental health problems. **The Review recommends that, in relation to future deaths in police custody, the IPCC look not only at police involvement in the circumstances surrounding the death, but also more widely at other issues, including the contribution of other agencies to the circumstances surrounding the death before contact with the police.**[291]

Changes in the structure and policies of the IPCC will help to address some of the issues raised by the investigation into the death of Sean Rigg. As the IPCC nears the end of its first decade, these changes need to be accompanied by changes in approach and team work at all levels of the organisation so that the IPCC can fulfil its difficult and challenging mandate. This will involve changes in methodology. It is beyond the capacity of the Review to enter into all the details of such changes, but two examples may serve to illustrate the direction to be taken.

Continuity of IPCC interviews with police officers

Interviews with the police officers involved in the circumstances surrounding a death in custody are bound to be highly sensitive and complex. For the purposes of analysis, the IPCC had to rely on their notes from the interviews and the tapes, which were not transcribed until the Coroner's Inquest. The continuity of interviewers was therefore important for recall and analysis.

IPCC interviews with a police officer normally involve two IPCC investigators: one leading the interview and the other present throughout, but generally only posing additional questions towards the end of the interview.[292] This good practice means that there are two perspectives on the interview, ensuring a greater degree of objectivity and internal self-criticism: it increases the identification of subtle points for further clarification, allowing greater scope for comparisons and contrasts that might reveal inconsistencies, enabling the reliability of accounts to be more incisively assessed.

However, the eight IPCC interviews with the four arresting police officers involved five different IPCC investigators leading, with five different IPCC investigators assisting. None of these interviews involved the same IPCC team: no individual IPCC investigator was involved in interviewing all four of the police officers who attended the scene. The January interviews concerning the allegations of assault were each led by different IPCC interviewers. Three of the four interviews in March 2009, which were longer and much broader in scope, were led by the same IPCC interviewer, but the fourth had a different lead interviewer and all four had different support

[291] See *Reynolds, R (on application of) v. IPCC & Anor* [2008] EWCA Civ 1160, [2009] 3 All ER 237, [2009] PTSR 1229, [2009] ACD 51, para. 25.

[292] The second IPCC interview with PC Glasson was conducted by an IPCC investigator without an assisting investigator.

interviewers. There was some degree of continuity between first and second interviews for individual officers. PC Birks was interviewed by the same IPCC lead interviewer both times, although with different assisting investigators. In the case of PC Glasson, the lead interviewer on his first interview assisted on his second interview. In the case of PC Forward, at both his IPCC interviews the assisting investigator was the same person. The investigator who interviewed PC Birks both times also interviewed PC Forward once and PC Glasson once.

Given that there had already been a delay of months, it would have made sense to space out the interviews, even if this meant an additional delay of a few days, both to ensure continuity of IPCC interviewers and to allow each interview to be analysed in turn, so as to benefit the conduct of the next interview. The ability of interviewers to compare and contrast the account from one officer with that from another was severely compromised by the lack of continuity across interviews and by the reliance on short interview summaries, in the absence of full transcripts.

Each of the four police officers who attended the scene was legally represented in the first of their two interviews, which involved allegations of a criminal offence, by the same solicitor. All eight interviews involved a representative of the Police Federation (PF); two PF representatives alternated attendance at interviews so that they each attended an interview with each officer. The Table below shows the participants in the interviews with the arresting officers.

Police Officer	**Date**	**IPCC Staff**	**Others**
PC Mark Harratt	19 Jan 09	Interviewer 1 Interviewer 2	Solicitor X PF rep. A
PC Andrew Birks	21 Jan 09	Interviewer 3 Interviewer 4	Solicitor X PF rep. B
PC Richard Glasson	22 Jan 09	Interviewer 5	Solicitor X PF rep. A
PC Matthew Forward	26 Jan 09	Interviewer 6 Interviewer 2	Solicitor X PF rep. B
PC Andrew Birks	18 Mar 09	Interviewer 3 Interviewer 7	 PF rep. A
PC Matthew Forward	18 Mar 09	Interviewer 3 Interviewer 2	 PF rep. A
PC Richard Glasson	26 Mar 09	Interviewer 3 Interviewer 5	 PF rep. B
PC Mark Harratt	26 Mar 09	Interviewer 8 Interviewer 9	 PF rep. B

Delay in transcribing the interviews

The content of the first series of interviews with the four arresting police officers was summarised by the interviewer in each instance. For example, the thirty-eight minute interview with PC Glasson was summarised in two pages: later a twenty-eight page transcription was made. The summaries do not provide the detail needed for either a thorough analysis of either the emerging information or inconsistencies in the police officers' accounts. It was possible to obtain the detail from the tapes, but it is not an easy process to analyse and compare taped material across four interviews.

The taped interviews with the police officers were not transcribed until the Coroner required them for the Inquest and decided to have them transcribed. The decision of the IPCC not to have the interviews transcribed may have been, in part, a matter of resources. The IPCC forensic budget can be used for transcription, but transcription is extremely costly. In the end, the cost of the transcription came out of the Coroner's budget. To the public, the cost implications are the same, but the implications for investigative effectiveness are not. The Review understands very well that the challenge facing the IPCC investigating the police services of England and Wales is an unequal struggle. Nevertheless, it considers it regrettable that transcription did not occur at a time when it could have proved valuable in the IPCC investigation. **Given the considerable cost of transcription, arrangements might be considered for sharing the expense across the IPCC and Coroner's Inquest. Transcripts should be made promptly, to ensure maximum benefit during investigations, including as regards facilitating case management and oversight, as well as at inquests. The Review recommends that it be standard practice to transcribe interviews promptly in investigations into deaths in custody.**

Interview plans and briefings

In light of this lack of continuity of interviewers, the one-page typed briefing initially provided to the IPCC interviewers,[293] and the variable interview plans, assume even greater importance. The interviews were not supposed to be individual exercises in gaining accounts of what happened: they should have been part of a concerted strategy to develop the thread of events, and to analyse actions and omissions, in order to gain insight into what went wrong.

The initial interviewers' briefing[294] lists eighteen questions as "points to be covered", but does not mention mental health issues explicitly, nor is the passport mentioned. Among the questions/points listed, five might be interpreted as approaching the issue of mental health:

- "What clothes was Sean Rigg wearing?"
- "What was Sean Rigg's demeanour upon arrival during arrest and thereafter?"
- "Sean Rigg's demeanour in the van and upon arrival at the police station."
- "What was Sean Rigg's demeanour [whilst the van waited in the yard]?
- "Was his demeanour different to what it was at the arrest scene and during the journey?"

[293] IPCC document D12.
[294] IPCC document D12.

For the March 2009 interviews, a significantly more detailed list of points was provided; this corresponded more closely to the wider scope of those interviews. It consisted of thirty-seven bullet points, including a question about the passport. The final series of questions related to mental health issues: "Did the officers know or suspect at any time that Sean Rigg suffered from mental illness? If so, did this make a difference to how Sean Rigg was dealt with throughout his arrest and detention. And did the officers bring this to the attention of the Custody Sergeant?"[295] Despite this briefing, the plans for the individual interviews vary considerably on a spectrum from somewhat sketchy to organised, detailed and fairly comprehensive.

The IPCC internal review of the Rigg investigation looked at the interview plans and the summaries of the interviews, but the transcripts of the interviews were not available. On that basis, the internal review found the interviews to be well planned and conducted.

The Review team considers that the IPCC interviews were not as fully prepared as they might have been, for the reasons mentioned above: the lack of continuity of interviewers, the close timing of the interviews, the lack of transcripts for comparison across interviews, the issues omitted from the briefing, and the lack of analytical content and strategic approach in the planning of interviews.

The IPCC interviewers' stance towards the police officers

The interviewers did not pursue failures on the part of the police with sufficient rigour (e.g. the police officers' failure to establish that the passport was Mr Rigg's and their failure to recognise indicators of mental illness). Most of the interviewers appeared ready to accept the police officers' view of events without following up potential lines of questioning. Some of the IPCC interviewers appeared to have the same expectations about police performance as the police officers' own understanding of what might have been expected of them. **Those expectations were generally low; in the opinion of the Review, they do not always correspond to acceptable standards for police performance.**

From the transcripts of the IPCC interviews with the police officers, it appears that the IPCC investigators empathised with the pressures of police work. It is important to understand the difficulties of policing when confronted with a person who is strong, fit and acting in a violent way. It is also important not to identify too closely with the person being interviewed, as there is a real risk of overlooking shortcomings in that person's account. Some of the questions were posed to the police officers almost in an apologetic manner. This is apparent particularly when the IPCC asked the police officers questions raised by the Rigg family in their complaints. The questions were described by the IPCC as being 'random'; at times the interviewer explained that a question had been asked by the family and the IPCC was therefore obliged to raise it. There appeared to be an attempt to distance the IPCC from these questions.

[295] Word-processed document provided to the Review team, not listed on HOLMES and with no IPCC code.

The role of the Police Federation representative

The control of the IPCC interviews did not remain consistently with the IPCC. At times a PF representative was aggressive and appeared to step out of role, including by giving answers to interview questions. For example, in one interview, when the IPCC interviewer posed the pertinent question as to whether or not the police officer felt properly trained and equipped to deal with the kind of situation that arose, the police officer replied in the affirmative.[296] The PF representative then intervened.

> PF rep.: "You have to bear in mind as well though that the service that [officer's first name] had at the time which, I don't know if you've covered that in a previous interview or not. But [officer's first name] had yet to pass out."
> IPCC interviewer: "Yes, I mean it's--"
> PF rep.: "Oh, you were coming to that, were you?"
> IPCC interviewer: "We have seen your training records but obviously you're a new officer in post."
> PF rep.: "The thing of being a police officer, you never know if you've been trained in something until it happens."
> IPCC interviewer: "I appreciate that."

In another IPCC interview,[297] the PF representative gave a long explanation of the current policy in Brixton regarding radioing to the station to check on space at the custody suite; he then turned to the police officer being interviewed by the IPCC and asked him to confirm this. When the IPCC interviewer then posed a further question, the PF representative again gave a long response.

In reaction to the IPCC interviewer's question concerning allegations that one or more police officers assaulted Mr Rigg by throwing him into the van, the PF representative intervened with the question "What is the evidence for that?" The IPCC interviewer explained apologetically "that's an allegation that's been put to us … I appreciate this is difficult for you to answer an allegation where there's no supporting evidence".[298]

At a late stage in another IPCC interviews,[299] the PF representative asked about Mr Rigg's mental health: "About mental health issues, I just wondered, did Mr Rigg have any mental health issues?" The IPCC interviewer replied, "Well, yes." The PF representative responded, "He did, did he?" When the PF representative pursued this further, asking what type of mental health issues Mr Rigg had, the IPCC interviewer said that she would have to "get back to him on that."

During one of the IPCC interviews, the lead interviewer paused, saying, "Just bear with me, I just want to make sure I've covered everything we need to cover."[300] At this point, the PF representative said that there were some points that he would like to raise and the lead IPCC interviewer said, "Yes, yes". The PF representative then proceeded to put, to the police officer, each of the four issues that

[296] IPCC interview with PC Forward, 18 March 2009, transcript pp. 29-30.
[297] IPCC interview with PC Harratt, 26 March 2009, transcript p. 46.
[298] IPCC interview with PC Birks, 18 March 2009, transcript p. 30.
[299] IPCC interview with PC Forward, 18 March 2009, transcript p. 4.
[300] IPCC interview with PC Harratt, 26 March 2009, transcript pp. 43-44.

might have given rise to disciplinary action; the officer denied them all. The lead interviewer continued questioning the officer. Then the PF representative joined in the questioning, asking about police policy in Brixton at the time. The PF representative also answered one of the questions the second IPCC interviewer directed to the police officer; the PF representative's long response about policing in Lambeth covers, without any interruption, more than a page of transcript.[301]

The Review notes that the IPCC interviewer began the interview by explaining that the "Police Federation representative will not be able to answer questions on your behalf or otherwise interfere with the process of the interview. However, if you wish to consult with him at any time just tell me, we'll stop the interview and we'll give you a room to be able to consult in private."[302] Unfortunately, that did not prevent the PF representative from intervening inappropriately.

The above examples show the PF representative behaving inappropriately, including making arguments on behalf of the police officer and questioning the IPCC interviewer. The transcripts of the interviews with the arresting police officers paint a picture of an uneasy working relationship, with interviewers at times appearing hesitant to put to the police officers fundamental questions about how they exercised their duty of care. When someone dies in police custody, IPCC investigators are entitled to expect the fullest possible level of co-operation from the police during the IPCC investigation of how the police have discharged their public duties. **The Review recommends that the IPCC, police and the PF agree detailed protocols about the role of the PF representative and what is acceptable conduct at IPCC interviews.**

The IPCC's role

After almost ten years in existence, it is time to take stock and reconsider the IPCC's role. The classic reflex of complaints authorities is to focus on complaints. However, when there is a death in custody, the IPCC investigation does not depend on a complaint: the remit of the IPCC goes beyond investigating and responding to individual complaints. In cases of deaths in custody, the public has an interest in, and an expectation of, the IPCC. It expects the IPCC to fulfil its guardianship role and test whether the State has met its obligations arising from Article 2 of the European Convention on Human Rights (ECHR): to protect the right to life. In accordance with the jurisprudence of the European Court of Human Rights, the United Kingdom is obliged to ensure effective investigation into deaths in custody in order both to provide an effective remedy in law and to prevent such an event from happening again. The IPCC's role encompasses that duty. The IPCC fulfils that duty by looking into all the circumstances of an individual's death in police custody effectively and thoroughly, and deriving lessons for future improvement of safeguards. The public expects nothing less.

The requirements of a truly independent and effective investigation are that it be thorough, prompt, impartial and rigorous. Translating this into effective working methods is complex. The targeted objectives of an individual investigation into a death in custody include establishing the truth, identifying possible criminal offending, identifying possible misconduct, and identifying failures of

[301] IPCC interview with PC Harratt, 26 March 2009, transcript of first tape pp. 46-48.
[302] IPCC interview with PC Harratt, 26 March 2009, transcript p. 3.

individuals and of the system, even if these do not reach the threshold of criminal offence or misconduct.

An IPCC investigation aims to probe for the truth in an individual case, to address public concerns, and to draw out lessons for the future. A broader concept of the IPCC's role would encompass contributing to improvements in the system of policing so as to prevent deaths in custody. By identifying gaps and practical shortcomings in individual cases, the IPCC is in prime position to identify patterns of systemic weakness across cases and, thus, to recommend changes to policy and operations in order to prevent recurrence. The preventive role of the IPCC requires a more proactive and holistic approach to understanding the circumstances surrounding deaths in custody.

The standards to be applied by the IPCC

If the IPCC's role is limited to assessing officers' actions against criteria and standards derived from the police guidance applicable at the time, this will produce an external audit of police work in cases where a death or serious injury occurs, or there is a complaint to be answered. Auditing is an important function, but arguably the public has the right to expect more of the IPCC.

The police regulations, standard operating procedures and guidance on dealing with persons with mental illness may be a fair starting point for assessing whether an individual officer has behaved appropriately, but the Review suggests that there is also a need to review the regulations, procedures and guidance, and to identify any shortcoming therein. If the police guidance is insufficient, it could be argued that it is unfair to hold individual officers to blame for complying with the guidance. However, for the IPCC, there is also the matter of holding the system to account. The key questions are what should reasonably be expected of the police in the circumstances and whether compliance with police guidance adequately reflects the duty of care to people in police custody.

This implies that the IPCC should develop its own criteria for assessment. The Review recommends that the IPCC develop, and articulate for IPCC staff, clear expectations and independent criteria for assessing police conduct. It should be recalled that the IPCC was set up in the context of a long-standing and broader debate about compliance with the ECHR. In this wider context, the test is ultimately whether or not policing policy and practice complies with human rights jurisprudence and standards for combating impunity.

Sustained organisational learning

Beyond the detailed gathering of information and compiling of evidence in a single case, there is a need for the IPCC to look analytically at the substantive and methodological issues arising in a single case and across cases. The Review understands that the Learning Lessons Database is now accessible to everyone at the IPCC. This contains all national and local recommendations made in past investigations, as well as examples of good practice; a different issue relevant to the IPCC's work is covered in each issue of the Learning Lessons Bulletin, which is also circulated to the ACPO. **The Review recommends that continuing efforts be made to ensure that IPCC investigations become part of an iterative process, so that there can be sustained organisational**

learning: structures and practices should be kept under review to ensure that this happens in practice.

In the past there appears to have been a lack of IPCC follow-up across cases of recommendations, and also little analysis of systemic weaknesses and gaps in safeguards. This may be due in part to resource constraints and partly to over-reliance on traditional methods. For example, HOLMES (Home Office Large Major Enquiry System) is excellent as a record of individual items of evidence, but is less useful for analytical purposes since data are not stored in a thematic way, making information retrieval and analysis more difficult. **The Review suggests that the IPCC give thought to developing a system for storing information in an analytical way, so that it can be searched and used for analytical purposes (e.g. to compare and contrast cases, to establish patterns, and to identify recurring issues). The Review understands that moves in this direction are part of the new IPCC policy, agreed in February 2013.**[303]

The system recommended above could also be useful for reviewing IPCC methodology through a combination of reflective practices and on-going training. The Review understands that the new guidance includes provision for planning and team debriefing.[304] In particular, there is now a debriefing requirement for all those involved in every independent investigation, including the Commissioner, the senior investigator, investigators, and the FLM.

There is a need to regularly review methods specific to the role and functions of the IPCC. The review recommends discussion and exchanges across the IPCC to build a common sense of direction. An ethos of independence and rigour needs to be fostered constantly when holding the police and, if appropriate, other agencies to public account for their involvement in the circumstances surrounding a death in custody. Team building beyond investigative staff appears to be needed in order that the IPCC can gain maximum benefit from all who belong to the organisation.

Given the incidence of mental health issues in relation to deaths in custody, the Review considers that IPCC investigators require enhanced mental health awareness training beyond the level provided to the police; they would then be in a better position to take a view on the training available to, and standards required of, the police, including being able to assess the need for a more standardised and systematic approach to police training on mental health issues. **The Review recommends multi-disciplinary training and team-building involving all levels of the IPCC, including legal advisers and experts in specialised fields (e.g. mental health, restraint, and information technology).**

On-going training is also necessary on more technical matters. Training for investigators would promote consistency particularly in terms of interviewing. IPCC interviewing demands methods different from police interviewing: the focus should be on preparation and adoption of an analytical strategy to address key issues, robust questioning, pursuing the implications of answers (including what is left unsaid), and probing the basis for an account and the attitudes behind it. A corollary of this, to ensure a strategic approach and analytical rigour, would be further training for senior staff in managing investigative work, supervising, and supporting the process of drafting reports. The

[303] IPCC, Revised IPCC Statutory Guidance, 2013. Available at http://www.ipcc.gov.uk/en/Pages/statutoryguidance.aspx.
[304] IPCC, Revised IPCC Statutory Guidance, 2013.

Review understands that there have been a number of initiatives to promote a more uniform approach; these include the introduction of a style template for investigation reports in 2010, and a template for the Commissioner's Foreword in February 2013.

Resources

Many of the suggestions flowing from the Review have resource implications, though the question of resources has not been the focus of this Review. It is impossible not to recognise the severe resource limitations under which the IPCC is constrained to operate. The Review recommends that these limitations be reviewed and remedied. The Home Affairs Committee has addressed this incisively: "Compared with the might of the 43 police forces in England and Wales, the IPCC is woefully underequipped and hamstrung in achieving its original objectives. It has neither the powers nor the resources that it needs to get to the truth when the integrity of the police is in doubt. Smaller even than the Professional Standards Department of the Metropolitan Police, the Commission is not even first among equals, yet it is meant to be the backstop of the system. It lacks the investigative resources necessary to get to the truth; police forces are too often left to investigate themselves; and the voice of the IPCC does not have binding authority. The Commission must bring the police complaints system up to scratch and the Government must give it the powers that it needs to do so."[305]

[305] Home Affairs Committee, Eleventh Report: IPCC, 29 January 2013, para.5. Available at http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/49402.htm.

Appendix A: The independent external review team

Dr Silvia Casale (M.A. Oxon., M.A. U.Penn., M.Phil. Yale, Ph.D. Yale)

Silvia Casale is a criminologist. She works as independent adviser to the Council of Europe on training Parliamentarians in immigration detention monitoring and on capacity-building programmes for national preventive mechanisms.

She was the member in respect of the United Kingdom of the European Committee for the Prevention of Torture and inhuman or degrading treatment or punishment from 1997 to 2009, and its President from 2000 to 2007. In 2007, she became the first Chairperson of the newly established United Nations treaty body the Subcommittee on Prevention of Torture and other cruel, inhuman or degrading treatment or punishment, serving as the member in respect of the United Kingdom from 2007 to 2009.

From 1998 until July 2012, she worked as a Northern Ireland Sentence Review Commissioner (re: release and recall of terrorist prisoners under the Good Friday Agreement) and has been a member of the International Contact Group (peace initiative in the Basque Country) since 2009. Previously, she was a member of the Parole Board for England and Wales (1988-1990) and an independent consultant to HM Prisons Inspectorate, England and Wales (1991-2005).

She is a long-standing trustee of the Prison Reform Trust, and from 1991 to 2012 was a trustee of the Prisoners Advice and Care Trust. She is a patron of UNLOCK (the national association of reformed prisoners in the UK) and of the Writers in Prison Foundation, and serves on the Advisory Board of the Association for the Prevention of Torture in Geneva.

Martin John Corfe

Registered mental health nurse (1987); ENB Teaching and Assessing in Clinical Practice (1989); Trainer RCP (1996); BSc Specialist Practitioner (1997); ENB Child Protection (1998)

In 1987, Martin Corfe worked as the staff nurse at Ashen Hill Medium Secure unit. In 1988, he became charge nurse, managing on a shift-to-shift basis, completing assessments in prisons and specials hospitals, and advising the multidisciplinary team, including medical staff, on safety matters.

In 1992, he was part of a professional group (including representatives from the probation service, courts, and the CPS) who developed a plan for a court diversion service for East Sussex, which included the Brighton and Hove area. The scheme was funded in part by the Home Office and covered the area of three mental health trusts.

In 1996, he left for a year to undertake a degree; during that time he worked with a community mental health team, a substance misuse service, and older adult services.

In 1998, he supervised a small team, becoming the lead nurse with responsibility for (i) the assessors in the Prison In-reach team at Lewes Prison, (ii) four community nurses in forensic psychiatry, and (iii) community nurses with the court liaison service.

In 2005, he completed a detailed clinical audit for trust managers that looked at the problems caused by poor outcomes in relation to use of civil mental health sections. During this time he also developed collaboration with the Mental Health Unit of the National Association for the Care and Resettlement of Offenders. In 2006, he was asked to lead a fourteen-day prison pilot, funded by the Department of Health; this measured the time taken for Section 48 and Section 47 transfers from prison.

In 2007, he was asked to take over the management of the West Sussex Criminal Justice Liaison Team, focusing on criminal justice liaison work over a larger geographical area. During 2010 and 2011, he completed an audit of people coming through the courts and prison requiring transfer who could have been transferred under a civil section at an earlier point in their care. This showed variations in outcome between patients from different geographical areas, which were reported to managers and stakeholders; action was subsequently taken. In his last year with Sussex Partnership Trust, he was involved in preparations for a point-of-arrest service across Sussex.

In April 2012, Martin Corfe took partial retirement from the NHS and began working in a part-time advisory capacity and in voluntary work.

James Lewis QC

James Lewis QC has been a barrister in independent practice for twenty-six years. He is experienced in criminal and public law, and appears frequently in courts at first instance, the Court of Appeal, the Privy Council, and the Supreme Court, as well as in other foreign jurisdictions, being additionally called *ad hoc* to the bars of Gibraltar, Cayman Islands, Brunei, Trinidad and Tobago, and Ireland. His practice involves appearing both for the prosecution and the defence, and he has appeared in a large number of important and well-known cases. He is on the list of approved Queen's Counsel to prosecute for the Serious Fraud Office.

In 1999 he was appointed to the Attorney General's List (civil) and made a Recorder of the Crown Court in 2000. He took silk in 2002.

In 2006 he was appointed as Tutor Judge at the Judicial Studies Board (now the Judicial College) and made a Bencher of Gray's Inn in 2007. He was made a member of the Criminal Committee of the Judicial College in 2008 and served as a member of the Advisory Group to the Sentencing Council.

In 2011 he was authorised to sit as a judge at the Central Criminal Court (the Old Bailey) and in 2013 was appointed as a Deputy High Court Judge assigned to the Administrative Court.

He is currently instructed as leading counsel for the IPCC in the Hillsborough Inquests.

Appendix B: Terms of reference for the Review

a. To review the investigation carried out by the IPCC in light of the evidence given at the inquest and the verdict;

b. To take account of the concerns of the Rigg family about the effectiveness and approach of the investigation;

c. To determine whether to recommend that further investigation is required into the conduct of any police officer or member of police staff with a view either to misconduct or criminal proceedings;

d. To identify any learning including:

   i. Any organisational or individual learning for the IPCC in its handling of investigations that engage Article 2 of the ECHR and investigations that involve mental health issues;

   ii. Any broader issues or questions either for the IPCC or the overall system for investigating deaths following police contact, to inform the review into deaths following police contact already launched by the IPCC;

   iii. Any issues raised by the relationships between the IPCC and the coronial process; and

e. To take account of the parallel review of health and social care support being carried out by Lambeth Safeguarding Adults Partnership Board.

Appendix C: Persons and organisations consulted during the Review

This review has benefited from consultations with

- the IPCC, who have given much needed assistance, including providing access to and copies of materials, explanations of record systems, clarifications, IT support, and comments, for all of which the Review is very grateful;

- members of the Rigg family, for their cooperation, knowledge, experience, concerns, insights and patience, and for respecting the confidentiality of the Review;

- Daniel Machover and colleagues from Hickman & Rose, solicitors for the Rigg family, for cooperation, meetings, and provision of materials relating to the investigation and the Coroner's Inquest;

- the parallel review by Lambeth Safeguarding Adults Partnership Board;

- the South Lambeth and Maudsley NHS Trust Foundation;

- the wider review of deaths following police contact being advised by an external reference group chaired by Dame Anne Owers and consisting of Lord Dhoulakia, Deborah Coles (co-director of the charity INQUEST), Professor Mike Hough (co-director of the Institute for Criminal Policy Research), and Matthew Ryder QC;

- the independent review of mental health and policing, through a meeting with Rowena Daw and Melba Wilson;

- Deborah Coles and Vick McNally from the charity INQUEST, who provided important insights from their breadth of expertise across cases of deaths in custody, including in a written submission to the review;

- Detective Constable Jonathan Payne, from the Directorate of Professional Standards of the Metropolitan Police Service, for facilitating access to the police van, and to plans of the 2008 custody area at Brixton Police Station and the new plans for refurbishment; and

- Dr Peter Green of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London, for advice and information about training developments.

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The review team also referred to the information on the HOLMES system designated as material in the investigation of the death of Sean Rigg, in addition to handwritten materials, emails, items in evidence, and unused materials.

Appendix E: List of key abbreviations and acronyms

ACPO	Association of Chief Police Officers
BCU	Borough Command Unit (of Lambeth Borough Police)
CAD	Computer Aided Despatch (from the police call centre) A message created by an operator when a police response is requested
CCC	Central Communications Command (of the Metropolitan Police Service)
CIMT	Critical Incident Management Team (of the IPCC)
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CPT	European Committee for the prevention of Torture and inhuman or degrading treatment or punishment
CTO	Community Treatment Order
DPP	Director of Public Prosecutions
DPS	Department of Professional Standards (of the Metropolitan Police Service)
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
FCMHT	Forensic Community Mental Health Team
FLO	Family Liaison Officer (of the Police)
FLM	Family Liaison Manager (of the IPCC)
FME	Forensic Medical Examiner
FMHU	Forensic Mental Health Unit
GMC	General Medical Council
HOLMES	Home Office Large Major Enquiry System
IBO	Integrated Borough Operations Lambeth Borough system for handling 999 calls

ICPR	Institute for Criminal Policy Research
ICV	Independent Custody Visitors
IPCC	Independent Police Complaints Commission
LAS	London Ambulance service
LBL	London Borough of Lambeth
LSAPB	Lambeth Safeguarding Adults Partnership Board
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Mobile Data Terminal (in police vehicle)
MHA	Mental Health Act
MPS	Metropolitan Police Service
NSIR	National Standard of Incident Reporting National classification system for 999 calls: the grading of calls dictates the type of police response
PACE	Police and Criminal Evidence Act
PICU	Psychiatric Intensive Care Unit
PNC	Police National Computer Database of criminal records
RMO	Responsible Medical Officer
SLaM	South London and Maudsley NHS Foundation Trust