independent police complaints commission

IPCC Independent Investigation into the death of Sean Rigg whilst in the custody of Brixton police

and complaints made by Mr Wayne Rigg and Ms Angela Wood

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Introduction

1. This is a report detailing the findings of an independent investigation carried out by the Independent Police Complaints Commission (IPCC) into the death Mr Sean Rigg on 21 August 2008. Mr Rigg was arrested on 21 August 2008 and following his arrest, his health noticeably deteriorated whilst in the custody of officers from the Metropolitan Police Service (MPS). Mr Rigg was pronounced dead at King's College Hospital at 9.24pm.

2. Mr Rigg was a resident of the Penrose Housing Authority Focus Project at Fairmount Road, Brixton, London, SW2. This project offers varying levels of support and guidance to individuals with mental health issues.

3. At 4.53pm on 21 August, a worker at the Fairmount Road Project dialled 999 to report that one of their residents, Mr Rigg, was showing signs of a breakdown and behaving in a threatening manner towards staff. The hostel workers believed that he had not taken his medication for some time.

4. Two further 999 calls were made by hostel staff at 5.32pm and 6.46pm stating that Mr Rigg was still behaving aggressively and that he had also damaged some garden furniture. The police did not attend the Fairmount Road Project until 8pm.

5. At approximately 7.08pm, Mr Rigg left the hostel and walked south along Brixton Hill wearing trousers but no shirt.

6. Mr Rigg was seen, by two members of the public, attempting to physically attack a man walking along Brixton Hill. These two members of the public both dialled 999 to report the incident.

7. Shortly after this report a police van arrived containing four officers

from Lambeth Borough Command Unit (BCU). A member of the public pointed them in Mr Rigg's direction. A short foot pursuit ensued, that resulted in Mr Rigg being apprehended on the Weir Road Estate.

8. Mr Rigg was arrested at approximately 7.40pm, and transported to Brixton Police Station arriving at the station at approximately 7.52pm. A little over 20 minutes after his arrival, an ambulance was called for him and he was taken to Kings College Hospital where he was pronounced dead at 9.24pm.

9. The MPS Department of Professional Standards (DPS) were called, who in turn notified the IPCC of the incident.

10. The IPCC Regional Director, Mr Derek Bradon, decided that the mode of investigation into Mr Rigg's death should be that of independent investigation. This meant that the Commission would carry out the investigation into the incident using its own independent investigators.

Terms of reference

11. To investigate the circumstances surrounding the police contact with Sean Rigg on 21 August 2008 as follows:

    - The circumstances leading to a support worker telephoning the police in relation to the behaviour of Sean Rigg at 4.53pm.
    - The subsequent calls to the police about Sean Rigg and how those calls were managed.
    - The arrest of Sean Rigg and his transportation to Brixton police station and then to the custody suite.
    - His time in the custody holding cage up to him being taken to hospital by ambulance at 9.02pm.
    - The cause of his death and whether or not any acts or omissions of any police officer caused or contributed to his death.
    - To establish whether there were any systemic issues within the Metropolitan Police Service which caused or contributed to his death.
    - To establish whether any acts or omissions of any police officer were motivated by the ethnicity of Sean Rigg.
    - Post incident management.
    - The operation of the CCTV systems used in Brixton police station.

    To assist in fulfilling the state's investigative obligation arising under Art. 2 ECHR by ensuring as far as possible that:

    The full facts are brought to light and any lessons from the death are

learned and the investigation is independent on a practical as well as an institutional level.

To consider and report on whether any criminal or disciplinary offence may have been committed by any police officer or member of police staff involved in the incident, and whether there has been compliance with relevant local and national policies/guideline.

To consider and report on whether there is any:

- learning for any individual police officer or member of police staff; or
- organisational learning for the police service, including:
- whether any change in police policy or practice would help to prevent a recurrence of the event, incident or conduct investigated.
- whether the incident highlights any good practice that should be disseminated.

Complaints

12. The events of 21 August 2008 generated two complaints. The first was made by the family of Mr Rigg, specifically his brother, Mr Wayne Rigg. The second complaint came from Ms Angela Wood, the Project Manager of the residence where Mr Rigg lived.

Mr Wayne Rigg

13. Mr Wayne Rigg is legally represented by the law firm Hickman and Rose. A letter of complaint was received by e-mail on 12 October 2008, from Hickman and Rose solicitors.

14. The complaints made by Hickman and Rose on behalf of Mr Wayne Rigg are recounted below.

Our client, Wayne Rigg, has instructed us to make the following formal police complaint in relation to alleged misconduct towards Sean Rigg by officers employed by the Commissioner of Police of the Metropolis.

- *The police failed to respond appropriately to approximately six calls for assistance made by staff at the Fairmount Road Hostel, London SW2, commencing shortly before 5pm on 21 August 2008. This amounted to neglect of duty and very possibly a breach of local policies (i.e. contrary to Paragraph 5 of the Code of Conduct which requires that "officers should be conscientious and diligent in the performance of their duties").*

- *When the officers concerned detained Sean at approximately 7.15pm on 21 August, none of them (or the officers or other police staff in communication with the officers at the scene) recognised that Sean was a person with mental health needs. Accordingly, this entailed a breach of the requirement that "officers should be conscientious and diligent in the performance of their duties". One or more officer was in breach of paragraph 5 of the Code of Conduct in this connection, either because the system in place failed to flag Sean up to the officers in question as someone known to and reported to the police as suffering from mental health problems OR because there was a failure by one or more officers to comply or follow the system in place in this regard.*

- *Alternatively, there was a breach of paragraph 5 of the Code of Conduct in as much as one or more officer did recognise that Sean Rigg was a person will mental health needs but failed to treat him as such.*

- *The detention of Sean Rigg in the Weir Road area by police officers involved a breach by one or more of the officers concerned of the criminal law and a use of force and abuse of authority contrary to paragraph 4 of the Police Code of Conduct which provides that "officers must never knowingly use more force than is reasonable, nor should they abuse their authority".*

- *Our client alleges that the officers involved carried out a serious assault or other assault on Sean Rigg as there was an unjustified use of force or personal violence which may have caused serious injury to Sean Rigg.*

- *As regards the subsequent detention of Sean further or in the alternative, the means by which they restrained him were not in accordance with local and national procedures on restraint of persons with mental illness or acute behavioural disturbance.*

- *Sean Rigg whilst being transported to Brixton police station, our client alleges that whilst in the van one or more of the officers involved carried out a serious assault or other assault on Sean Rigg as there was an unjustified use of force or personal violence which may have caused serious injury to Sean Rigg. This was in breach of the criminal law and paragraph 4 of the Code of Conduct.*

- *The briefing given to Dr Hunt prior to the first post mortem examination included reference to the effect that Sean "kicked off" in the police van. No explanation has been provided as to what techniques were used to restrain him. Further or in the alternative, officers failed to perform their duties in compliance with paragraph 5 of the Code of Conduct which provides that "officers should be conscientious and diligent in the performance of their duties".*

Based on the information currently available, it appears that one or

more officers breached paragraphs 4 and/or 5 of the Code of Conduct in that they:

- *Did not use the appropriate restraint techniques correctly; Failed to properly monitor Sean's medical condition;*
- *Failed to comply with national or local guidance in connection with the treatment of detainees who appear to have mental health problems;*
- *Failed to take proper steps to ensure that Sean was unharmed prior to being removed from the police van in a collapsed state; and/or*
- *Failed to ensure that he received proper medical attention as soon as it became apparent that Sean was seriously ill.*

The family make it absolutely clear that the fact that death resulted from the above events makes the police officers concerned suspects in the murder or manslaughter of Sean Rigg.

Further, they consider that if the IPCC during the course of the investigation forms the view that one or more officers has a case to answer that s/he used dangerous or excessive force on Sean Rigg, that the IPCC recommends to the Commissioner of Police of the Metropolis the immediate suspension of the officer(s) concerned, pending receipt of CPS advice on criminal charges.

In the period following Sean being taken to hospital, the police:

- *Failed to seal off the scene of Sean's arrest immediately;*
- *Interfered with the CCTV cameras at Brixton police station;*
- *Interfered with Sean's mobile phone;*
- *Arranged for people in the Weir Road area to be evicted without*

asking them whether they had witnessed the arrest.

In this, they failed to perform their duties in compliance with paragraph 5 of the Code of Conduct; failed to act with honesty and integrity as required by paragraph 1 of the Code of Conduct; and breached their statutory obligations under the Police Reform Act 2002. Paragraph 14B, Part 2, Schedule 2 to the 2002 Act.

In the weeks following Sean's death, police officers have attempted to interfere with the IPCC investigation by contacting staff at the Fairmount Road hostel.

As indicated by Samantha Rigg David at the meeting on 22 September 2008, certain police officers have approached staff at the Fairmount Road hostel on several occasions and asked for information on the progress and scope of the IPCC investigation and on their knowledge of events following Sean leaving the hostel on 21 August.

At the very least, the conduct of these officers is a serious breach of paragraph 5 of the Code of Conduct and the family request that immediate action is taken to prevent any further attempts to hamper the IPCC's investigation.

Ms Angela Wood

15. Ms Wood made her complaint by way of an e-mail to the Lambeth Borough Commander, Chief Superintendent (Ch Supt) Sharon Rowe on 28 August 2008.

16. In this e-mail she outlines her complaint as follows.

My complaint is concerned with the conduct of the staff that were working in the Control Room on the 21st August 2008 from 16.00 to 20.00hrs. The complaint is with reference to CAD no: 6148. This CAD no. pertains to an incident that occurred at Fairmount Road

project concerning Mr Sean Rigg who later died in Police custody. The conduct of the Control Room was unprofessional and at times exasperating and unbelievable. I make particular reference to a member of your team who identified himself to me as Gluck. The following list details the timings of the calls made to your Control room, at times begging for Police assistance which were overlooked and ignored until 20.12:

16.53 call made (999)
17.09 2nd call made
17.32 3rd call made (criminal damage call)
18.46 4th call made
19.19 5th call made by AW
19.52 6th call made by AW
20.12 Police arrive at Fairmount Road

My complaint is twofold:

Firstly, I find it unbelievable that an emergency call that was made at 16.53 is ignored until 20.12. This is, in my opinion, an inexcusable length of time for the public to wait for Police assistance in an emergency.

The second part of complaint is concerned with the call made by me at 19.52. The officer/police personnel displayed a level of ignorance and arrogance that was shocking and angered me greatly. I am sure that you will have access to a transcript of this call however; I request that the following is accepted as an overview:

When I stated that Mr Rigg was actively psychotic, an expert in martial arts and therefore a risk to the Public I was informed by (Mr) Gluck that a unit would not be made available. When I questioned whether he understood what I meant by 'actively psychotic' he stated that he had a psychology degree and a black belt in karate and therefore understood and that still no unit would be made

available.

When I requested police assistance and was informed that none would be made he followed this up by advising me to write to my MP if I did not like it.

when [sic] *reiterated that Mr Rigg was risk to public safety due to his current psychotic state (Mr) Gluck responded that if I was that worried I should call for a Paramedic. I stated that due to the risk posed it would be 'suicidal' to expect a Paramedic to interact with Mr Rigg in his current state. To this (Mr) Gluck reiterated that if I was that worried I should call for a Paramedic. I informed him that my risk assessment would not let me do this without Police assistance. (Mr) Gluck then stated that I was 'going around in circles' and that we would not be getting Police assistance and that he was going to end the call.*

In complete and utter exasperation I requested his risk assessment of the situation to which he responded that no unit would be made available. I informed him that that was not a risk assessment and requested again his risk assessment of the situation. He reiterated that a unit would not be made available. I then reiterated that this was not a risk assessment and requested his risk assessment of the situation. He further reiterated that a unit would not be made available and then stated that as we were going around in circles and that I was tying up the line and other more important calls were not being answered he was going to end the call. (Mr) Gluck then ended my call.

I am staggered and angered at this response and I do wholeheartedly believe that had your team chosen to listen to me and my team from 16.53 Mr Rigg would be alive today. The response from a member of your team clearly demonstrates a complete disregard for public safety, mental health issues and an inability to gather information and act appropriately. Your team

member's response made me feel that the police felt that we were overreacting and ultimately were being a nuisance. In light of the gravity of the situation this should never have been the case.

I hereby request a formal investigation into the conduct of your team and further request that I am furnished with your findings. I await your response.

Officers under investigation

17. There are five police officers whose actions have been the subject of this investigation.

18. PC 299LX Richard GLASSON

PC 554LX Mark HARRATT

PC 550LX Matthew FORWARD

PC 271LX Andrew BIRKS

PS 113LX Paul WHITE

19. PC Glasson has been a police officer since November 2005, and was assigned to Brixton Police Station in December 2006. PC Glasson completed his Emergency Life Saving course in September 2006 and thereafter is required to attend a refresher course every three years. He attended this refresher in September 2009. PC Glasson's training record also shows that he was fully up to date with his Officer Safety Training.

20. PC Harratt has been a police officer since August 2007, and was assigned (full time) to Brixton on 8 September 2008. PC Harratt was still a probationary officer at the time of the incident but was fully qualified in both Emergency Life Saving and Officer Safety Training with his latest courses being in April 2009 and October 2008

respectively.

21. PC Forward became a police officer in February 2008 and was also a probationary officer. He was fully trained in Emergency Life Saving and Officer Safety Training.

22. PC Birks joined the Metropolitan Police Service in March 2008 having previously been an officer for City of London Police. He was immediately assigned to Brixton. PC Birks was fully up to date with his Officer Safety Training and Emergency Life Saving, and had also completed defibrillator training in December 2006.

Background

23. Mr Rigg was born in Birmingham on 11 February 1968, making him 40 years old at the time of his death. He was the fourth child born to Daniel and Marie. Mr Rigg was educated in Birmingham until the age of 12, when in 1980 he and his family moved to Tooting in south west London. Mr Rigg had one son who was born in 1987.

24. Mr Rigg was generally healthy as a young man. He did have the Sickle Cell trait, but was not affected by this.

25. Mr Rigg's family say that his mental health problems began when he was about 20 years old. The notes from his general practitioner show that he was diagnosed with Paranoid Schizophrenia in 1990. His notes also state that from 1990 to 2005, Mr Rigg was admitted to hospital 14 times under various sections of the Mental Health Act.

26. In 2004, Mr Rigg was admitted to mental health hospitals in both Switzerland and Thailand. He returned to England following both admissions.

27. In August 2006, Mr Rigg was prescribed Haloperidol Decanoate, an antipsychotic drug used to treat Schizophrenia.

28. Mr Rigg was admitted to Cain Hill Hospital on 14 August 2006 and discharged on 30 October 2006. He immediately took up residence at the Penrose Housing Authority Focus Project at Fairmount Road, Brixton.

29. This Focus Project is part of a scheme providing interim care for people with mental health issues who have been discharged from more secure mental health facilities. Mr Rigg was admitted to the low support unit with a primary diagnosis of Paranoid Schizophrenia. He was an informal patient at the hostel, and not subject to any provisions of the Mental Health Act. During his stay at this hostel Mr Rigg was admitted to hospital on two occasions for non compliance with his medication.

30. Mr Rigg's medication was administered by way of depot injection given on a three week cycle at Lambeth Hospital. This is a type of injection that keeps the medication at the site of the injection so that absorption occurs over a prolonged period of time.

31. The prescription, administering and monitoring of his medication is the responsibility of the Clinical Care Team provided by the South London and Maudsley NHS Foundation Trust (SL&M). SL&M is funded to provide a clinical service to the residents at the Focus Project in Fairmount Road. This service includes a psychiatrist, a social worker, a community nurse, an occupational therapist and a psychologist.

32. In March 2007, following an out-patients appointment Dr David Ndegwa states that Mr Rigg's mental state was, *"normal".* However, the doctor does go on to say that Mr Rigg wanted to change from administering his medication by depot injection to an oral method. Dr Ndegwa suggested that,

"…it is unfortunate that he is no longer interested in taking depot as it is the only medication that keeps him in remission for any

significant period".

33. Mr Rigg's Key Worker at the hostel was Mr Khalid Sadi. Mr Sadi remembered that in June 2008, Mr Rigg was showing signs that he may not have been taking his medication. Mr Sadi stated that,

    "He became easily frustrated and he started talking about his son and his ex partner inappropriately. These are some of the warning signs that Sean's mental health may be deteriorating…"

34. Mr Sadi says that he filled out a risk assessment to inform the other staff, but Mr Rigg's behaviour did not escalate or cause any further concern right away.

35. Mr Sadi had known Mr Rigg for 20 months prior to his death and says that,

    "The usual Sean (when on medication) is charming, articulate, talented, creative, jolly, interesting lovely person".

36. Mr Sadi also had experience of Mr Rigg's behavioural cycles. He states that,

    "I have worked with Sean before when his mental health has deteriorated and it usually results in him being arrested by police. He is then sectioned under the mental health act and therefore is forced to take medication. When Sean becomes stabilised he is usually released back to the project. He is often still subject to the section initially and so continues to take medication. When the section is lifted Sean takes the medication as and when he pleases and he eventually stops. Since I have known Sean this cycle has happened 3 times including the most recent time".

37. Mr Rigg attended an out-patient's review clinic on 17 July 2008, in order to receive his medication by injection. According to his care co-ordinator, Nurse Julie Emezi,

"He always complained about having to have his medication. He would often turn up late for appointments and state that he did not want it or need it. Sean was meant to have his injection every three weeks but sometimes he would drag out the time to every four weeks or every five. He also complained about the dosage level but this could not be changed as it was set by the doctors".

38. At this review, Mr Rigg met with Nurse Emezi and the Responsible Medical Officer (RMO), Professor Tom Fahy. Nurse Emezi says that she was attempting to help Mr Rigg move on with his life and with this in mind she had mentioned that there was an opportunity for Mr Rigg to move into a self contained flat. Mr Rigg had said that he did not want to move from Fairmount Road, as he didn't want to have to meet new staff. He also said that he felt safer where he was. However, after speaking to Professor Fahy he realised that if he moved into this new flat, it would facilitate his move to a council flat more quickly. This was the intended plan for Mr Rigg's future.

39. Ms Wood is the Focus Project manager at Fairmount Road. In her statement she talks about relapse indicators. These are types of behaviour that suggest that individuals may be heading for a relapse. She describes the relapse indicators for Mr Rigg as paranoia, isolating himself, becoming grandiose and talking about his son.

40. Ms Wood also recounts that Mr Rigg had not taken his medication for about four weeks prior to his death, and he was beginning to display "high risk indicators". Because of this, about three to four weeks before his death, Mr Rigg was put into the Scarlett file. This is a file that contains the details of those clients who are demonstrating medium to high risk behaviour.

Chronological summary of events

41. Mr Rigg died on 21 August 2008. The following section is an account of the significant events in Mr Rigg's life leading up to 21 August, and a detailed chronology of what happened on 21 August itself.

42. This account relies primarily on Closed Circuit Television (CCTV) footage and eyewitness testimony.

Monday 11 August 2008

43. Mr Sadi, Mr Rigg's key worker, had a meeting with him to discuss his referral to alternative accommodation. Mr Rigg had previously discussed this with Professor Fahy and Nurse Emezi. Mr Sadi recalls that during this meeting, Mr Rigg showed no interest in the subject of moving and therefore Mr Sadi felt that there was no point in taking the matter any further at this time.

44. Mr Sadi says that it was at this meeting that he,

> *"…noticed that his mental health had deteriorated. He was saying things that were not normal, talking about drinking urine – this is known as unusual ideations and is a strong sign that he was relapsing".*

45. The Focus Project notified the SL&M Care Team of this development.

46. Following the death of Mr Rigg, the Chief Executive Officer (CEO) of Penrose conducted a Serious Incident Review of the circumstances leading to his death. The CEO of Penrose is Ms Janice Horsman.

47. The purpose of this review was to,

- Clarify the events that led to Mr Rigg's death.
- Review Mr Rigg's progress within Penrose and to better understand the circumstances that led to his mental health relapse.

- Review the quality of service provided to Mr Rigg.
- Establish the learning points for future practice.
- Identify any changes required to Penrose's policy and procedural framework.

48. In her review, Ms Horsman states that following the meeting of Mr Sadi and Mr Rigg on 11 August, the Focus Project checked with Lambeth Hospital regarding Mr Rigg's medication. The Focus Project was informed that Mr Rigg had not taken his medication since June 2008, which according to Ms Horsman's report meant he had missed the last three scheduled doses.

49. Ms Horsman's report also alleges that,

"…the clinical team (from SL&M) *failed to show at the scheduled meeting on 11/8, when Sean's case was to be discussed".*

50. Following this meeting on 11 August, further arrangements were made for the Care Team to visit and assess Mr Rigg's mental state.

51. SL&M also prepared a report outlining their contact with Mr Rigg leading up to his death. Unfortunately, despite several requests, SL&M have not provided this investigation with a copy.

Wednesday 13 August 2008

52. Nurse Emezi, Dr Tim Rogers (RMO) and a medical student from the SL&M Care Team attended Fairmount Road hostel in order to carry out a mental health assessment of Mr Rigg. They saw Mr Rigg with his key worker, Mr Sadi.

53. Dr Rogers was not Mr Rigg's regular doctor and according to Mr Sadi, this scared him further.

At this meeting, Mr Sadi said of Mr Rigg that he was, *"frustrated and was not co-operating"*.

54. Nurse Emezi said that, *"He presented as hostile, irritable and angry…".* She goes on to say,

"He said that he did not want anything to do with us and that it was so hard for a black male to get out of the mental health system. He said that he was drinking his urine to purify the damage that the NHS bad medicine had caused him".

55. They were unable to complete their assessment as the session had to be terminated because of Mr Rigg's behaviour. Nurse Emezi said that after the meeting finished, she could see Mr Rigg speaking to Mr Sadi in the garden. She said that Mr Rigg seemed,

"…very angry and was gesticulating a lot and speaking very loudly…"

Because of the way Mr Rigg was behaving, the Care Team left the hostel by the back exit.

According to Ms Horsman's report, Mr Rigg's behaviour in the garden lasted for two hours resulting in a neighbour reporting it to the police. The report says that, *"…the police appeared, observed and drove off".*

56. There is no record of this report being made, or of police attending an incident at the hostel on this day.

57. When Nurse Emezi returned to her office, she called Mr Sadi. Mr Sadi said that Mr Rigg was very angry that new people (Dr Rogers) had come to see him, as he believed that he always ended up in hospital after he has been seen by new people. At the end of her call with Mr Sadi, Nurse Emezi says that she,

"…emphasised to Khalid to keep monitoring Sean and inform me of any changes".

58. Of this meeting, Ms Wood said that Mr Rigg was angry and frustrated, and it required her and Mr Sadi to speak to Mr Rigg for two hours afterwards.

59. Ms Wood also said,

"I was annoyed that the meeting had taken place when I was not aware – they had not told me. I was annoyed that they (Health Care Team) *had angered Sean and then did nothing to de-escalate it".*

60. Following the death of Mr Rigg, Dr Rogers wrote a letter to Professor Fahy dated 11 September 2008. In this letter, Dr Rogers recounts his previous involvement with Mr Rigg.

61. He explains in some detail the situation as it unfolded on 13 August. Dr Rogers says that at this very first meeting,

"Mr Rigg strode into the room with his shoulders thrown back and he focused upon me, as someone whom he did not recognise. It later became apparent that he had been very fearful that I had unfairly come to detain him in hospital".

Dr Rogers also writes in his letter that,

"To summarise the interaction, Mr Rigg was initially very angry upon seeing us. I lead the interview, although he did most of the speaking. I managed to calm him sufficiently for him to sit down before, after a few minutes, he once again became angry and stood up. I then found his demeanour to be threatening. After a total of around 10 to 15 minutes I terminated the interview as I feared that Mr Rigg would become physically aggressive towards me".

62. After the interview ended, Dr Rogers said that he was left with,

"…the overall impression of someone who was unhappy at our visit that day but also who was seemingly unduly hostile and aggressive

in his demeanour. He appeared to me to hold overvalued mistrustful ideas but not to have obviously displayed persecutory or paranoid delusions or other psychotic symptoms".

Dr Rogers continues by saying,

"Overall I felt that our assessment had neither confirmed nor excluded the possibility of a relapse, but that his level of aggression was concerning in the context of his history and his recent poor treatment adherence".

63. Dr Rogers told the Fairmount staff that he felt Mr Rigg's behaviour and mental state needed to be more vigilantly monitored and if there was any deterioration, then a Mental Health Act assessment may need to be considered.

64. Dr Rogers says that,

"The Fairmount staff agreed but indicated that they thought this would not be necessary".

65. Following this failed attempt at a mental health assessment, Nurse Emezi put Mr Rigg in the "Red Zone". This meant that the Care Team would discuss Mr Rigg on a twice daily basis.

Thursday 14 August 2008

66. Mr Rigg was the topic of a SL&M team clinical meeting where it was agreed that a further mental health act assessment was needed and preparations would be made to carry this out. The clinical team decided that a doctor who knew Mr Rigg should speak to him and encourage him to come to have his medication. This doctor was Dr Ndegwa. He contacted Mr Rigg about his medication, but Mr Rigg still refused to attend.

67. Also regarding Mr Rigg's condition on this day, Nurse Emezi says

that,

"I was in contact with the hostel staff approximately twice a day and they were saying that Sean was manageable and that he had been in his room and was only coming out when he needed something".

Friday 15 August 2008

68. SL&M wrote a letter to Mr Rigg, asking him to contact his Community Psychiatric Nurse (CPN) regarding his medication.

Monday 18 August 2008

69. Nurse Emezi visited Fairmount Road on another matter. Whilst there she spoke to Mr Sadi about Mr Rigg. She asked Mr Sadi if he thought that she should see Mr Rigg. They agreed that if she saw him it may frustrate him more. As she was on her own the decision was made for her not to visit Mr Rigg. It was decided that Mr Sadi would e-mail Nurse Emezi with updates regarding Mr Rigg's mental health.

    Mr Sadi did see Mr Rigg during the course of the following week but he says, *"…there was nothing further that merited concern".*

Tuesday 19 August 2008

70. Ms Wood says that she was,

    "…told by the care team that they were trying to organise a Mental Health Act Assessment….I was told that they were trying to get people in place to do the assessment".

71. The Focus Project continued to pass on their daily observations of Mr Rigg, to the care team, through the key worker.

Wednesday 20 August 2008

Ms Wood wanted to gather the residents of the hostel together to inform them of the death of one of their fellow residents. She and Mr Alvares knocked on Mr Rigg's door to ask him to attend the meeting. Ms Wood says that he eventually opened the door, but he seemed quite agitated. Mr Alvares asked him to come to the lounge for the meeting and Ms Wood recalls Mr Rigg's reply as, *"You are not going to hurt that girl are you?"* Mr Rigg then closed his door.

72. Mr John Stevens is the Deputy Manager at the Fairmount Road hostel. He says that following the meeting with the residents, the staff went upstairs to the office where Mr Alvares informed the staff about his encounter with Mr Rigg. Mr Stevens recalls that Mr Alvares said Mr Rigg was wearing just his underwear and seemed very intense and agitated.

73. Mr Sadi says Mr Alvares described Mr Rigg as appearing unwell and that he felt his mental health had deteriorated. As per the existing arrangements, Mr Sadi notified the CPN. He phoned Nurse Emezi, but he was informed that she was off work sick, and therefore Mr Sadi left a message with another nurse.

74. Ms Horsman mentions in her report that the key worker was also told that the RMO was on leave, although Mr Sadi does not recall this in his statement.

Thursday 21 August 2008

75. The chronology for this day relies on timings from various different sources. These timings originate from the personal recollections of witnesses, the hostel CCTV, local authority CCTV, Brixton Police Station CCTV and the times recorded by the Computer Aided Despatch (CAD) system.

76. The timings from these different sources vary, but by an amount that does not pervert any of the relevant incidents. The disparity in timings is usually less than one minute and never of a significant amount.

19:55:53hrs- Van arrival at Brixton Police Station

19:08:01hrs- SR Leaves Hostel

19:51:40hrs- Van at top of New Park Road

19:19:58hrs- SR on New Park Road

19:26:43hrs- SR at Junction New Park Road/ Streatham Place/ Atkins Road

Key
Police Going
Police Returning
Mr RIGG
CCTV Camera

At the hostel

77. On the morning of 21 August, Mr Sadi and Mr Alvares went to check on Mr Rigg. At some time between 11am and 11.30am they knocked on his door, but received no reply.

78. Later that afternoon between 4.15pm and 4.30pm, Mr Sadi and Mr Alvares again visited Mr Rigg's room to check on his welfare. This time they took keys to enable them to enter, should they again receive no reply.

79. They knocked on Mr Rigg's door but there was no answer. They shouted through the door for Mr Rigg saying they were intending to enter his room. Again they received no reply. Mr Alvares then says that,

"We then unlocked the door to his room with the key, but we didn't open the door because we heard movement, so we stepped back a little bit and the door swung open, and Sean was standing there with a very stony [sic] *and non-responsive look on his face. I noticed his left eye was red and potentially bloodshot. This was all in a matter of seconds and he started doing martial arts kartas* [sic] *in a robotic way, solid way. We tried to talk to him. We asked him "Sean, Sean, what are you doing, what's wrong?" but he did not respond. And then he started advancing towards us in a very robotic way whilst still doing the kartas. Khalid and I ran down the corridor and I closed the door behind me – the front door to the low support unit downstairs. We heard a kick to the door and I looked behind me but carried on going up the stairs".*

80. Mr Sadi describes this incident as follows,

"Sean was close to the door in a Kung Fu stance with a blank expression on his face. He was only wearing dark blue underpants. We tried to talk to him but there was no response. We realised that he did not recognise us so we decided to leave. As we moved away he advanced towards us using Kung Fu moves. The movement was

robotic and not particularly fast but we feared for our safety. Sean is an exponent of using Wing Chun, which is a form of Kung Fu. He was going through the stances when he advanced towards us. We returned to the main office leaving Sean downstairs.

81. Mr Sadi immediately called the Care Team to inform them of Mr Rigg's condition. He spoke to a nurse with whom he had spoken before, explained the situation and asked for someone to help who had dealt with Mr Rigg before. Mr Sadi recalls,

"I felt that the nurse was dismissing my calls because I had kept calling to speak to Julia in the previous days. She sounded frustrated with me calling her. I asked to speak to somebody who could help but she was not putting me through to anybody who would help so I put the phone down".

82. Mr Sadi immediately phoned back and spoke to a CPN who was helpful. He said he would get the acting manager to call him back. Within minutes, the Acting Manager, Ms Rosalind Green, called Mr Sadi and said that nobody could come to assess Mr Rigg that day. She asked to be updated on her mobile with regards to Mr Rigg's condition. Ms Green also said that she would fax Mr Rigg's details to the out of hours Mental Health Team, just in case they were to be called to attend to Mr Rigg.

83. During Mr Sadi's conversation with Ms Green, Mr Rigg had appeared in the front garden, shouting and performing Kung Fu stances.

84. At the same time as Mr Sadi was speaking to the Care Team, Mr Alvares was on the phone to his managers, Mr Stevens and Ms Wood who were both away from the hostel. Mr Alvares explained the situation and they agreed that Mr Stevens would return to the hostel.

85. Mr Sadi then had a discussion with his team, and the decision was made to call the police.

86. The content of the phone calls to the police and the subsequent handling and resulting actions will be covered in more detail later in this report.

87. At 4.53pm, Mr Alvares dialled 999 to report Mr Rigg's behaviour to the police. He told the call handler that Mr Rigg had not taken his medicine and that he was acting in a threatening manner.

88. The Fairmount Road hostel has a CCTV system that includes one camera with a view of the front of the hostel building and a small part of the front garden closest to the building. This CCTV footage was recovered by this investigation and shows the behaviour of Mr Rigg that prompted the hostel staff to phone 999.

89. At 5.04pm, Mr Rigg can be seen on the CCTV footage walking up the steps that lead to the main front door of the hostel. He is wearing only shorts.

90. At 5.05pm, he re-appears and can be seen to do stretching exercises and seems to be practicing martial arts moves.

91. Throughout the next 32 minutes until 5.37pm, Mr Rigg is seen running and walking up and down the steps on numerous occasions, and practicing his martial arts moves.

92. At 5.38pm, Mr Rigg climbs up at the raised ground floor window by standing on the railing that protects the basement area.

93. Following this he appears on camera intermittently until 6.05pm when he is seen fully dressed at the front of the hostel.

94. At 5.32pm, Mr Stevens calls 999 to again report the continuing behaviour of Mr Rigg and to inform them of the damage Mr Rigg had

caused to some garden furniture.

95. At 6.46pm, Mr Alvares again calls 999 and states that Mr Rigg is now back in his room, but they can hear his shouting through the walls. Mr Alvares also says that he believes that Mr Rigg is a danger to other residents of the hostel.

96. At 7.01pm, Mr Rigg can be seen for a matter of seconds at the basement door of the hostel. He is wearing white trousers but no shirt.

97. At 7.08pm, Mr Rigg re-appears, walks briskly up the stairs from the basement area, into the garden. He then almost immediately disappears from view.

Brixton Hill

98. At 7.08pm, Mr Rigg leaves the hostel wearing just trousers and no shirt, and proceeds to walk south along Brixton Hill in the general direction of Streatham.

99. Mr Rigg's walk from the hostel to Atkins Road is captured in parts by the local authority CCTV. This walk from Fairmount Road to the scene of his arrest in the vicinity of the Weir Road Estate is approximately 1 mile (1.6km).

100. At approximately 7.07pm (time shown on local authority CCTV), Mr Rigg is captured by local authority CCTV walking along Brixton Hill. After approximately one minute Mr Rigg stops and begins to perform martial arts type kicks and punches. He does this for about 10 seconds before moving on.

101. At approximately 7.09pm, Mr Rigg goes out of view of this particular CCTV camera. Just under five minutes later Mr Rigg re-appears on a different camera further along Brixton Hill walking on the opposite

pavement.

102. Mr Rigg is caught on this camera for only a matter of seconds before he again goes out of view.

103. The next sighting of Mr Rigg is as he is walking along New Park Road, heading in the direction of Atkins Road. According to the CCTV timing it is now 7.15pm.

104. At 7.18pm, Mr Rigg can be seen walking west along Atkins Road on the northern pavement. A few seconds later a member of the public crosses the road from the north pavement to the south following what appears to be some sort of altercation with Mr Rigg. At the same time, another person approaches Mr Rigg from behind. Mr Rigg stops walking and turns to face this member of the public.

105. Approximately 20 seconds later Mr Rigg appears to be in an altercation with two other people near a parked car. These two people run across the road to the south pavement. Mr Rigg then walks into the road, and takes up what could be described as a martial arts stance. His legs are spread, knees bent, arms raised above his head and to the side with his elbows bent.

106. Mr Rigg holds this pose for a few seconds and then returns to the pavement. He continues to walk west on Atkins Road where his progress is now being watched by some members of the public.

107. At 7.19pm, Ms Wood makes the fourth 999 call from hostel staff about the behaviour of Mr Rigg. Ms Wood is not at the hostel at the time of this call and appears to be unaware that Mr Rigg has already left.

108. At approximately 7.21pm, Mr Rigg seems to confront the driver of a car as it turns from Atkins Road into Tilson Gardens. A few seconds after this incident Mr Rigg is seen on the local authority CCTV for the final time as he goes out of view at the junction of Atkins Road and

Kings Avenue.

109. At 7.29pm, a member of the public, Witness A, dialled 999 to report that a man wearing just white trousers (Mr Rigg) had attempted to karate kick a member of the public who was just passing by. She was standing by the traffic lights at the junction of King's Avenue and Atkins Road. Witness A recalls in her statement that,

"…Male A (Mr Rigg) *launched himself at Male B's* (passer by) *head using a karate kick. I think he led with his left leg but both feet left the ground. Male B ducked and cowered and I don't think Male A made contact with him. Male A landed back on his feet".*

Witness A then states that,

"Male B then ran in the direction of Kings Avenue. Male A ran after him for about 15 feet but then stopped and turned back round towards the Weir Estate".

110. Whilst Witness A was speaking to the emergency call handler, Mr Liam Jung, made a 999 call that was registered at 7.30pm, describing the exact same incident as Witness A. Mr Jung's description of this incident was,

"As they got to each other the male with no top on immediately attacked him. There was a very short scuffle and they lurched over towards the hedge. The scuffle was 2/3 seconds long. The shirted male broke free and ran the last 10 yards of Atkins Road. The male with no shirt pursued him for 2 or 3 paces but then stopped, turned round and walked back down Atkins Rd".

111. Moments later Mr Jung lost sight of Mr Rigg at the roundabout of the junction of Weir Road and Aktins Road. He recalls that,

"After 5 – 10 secs of going out of sight a male and a female came running into Atkins Road….I asked the couple if they had just been

attacked and they said they had".

112. During the course of Mr Jung's conversation with the call handler, a police van arrived. Mr Jung recalls that,

"The police passed me and pulled off the road in front of the male, they could have pulled onto a drive. Up until this point the male is still walking to Balham. The police vehicle was a white transit van and I don't think it had any windows".

Mr Jung goes on to say that,

"The back passenger side door has slid open (this is the main door at the back of the vehicle) and the male has immediately turned right and ran across Weir Road pursued straight away by 5 or 6 uniformed male officers. They ran into a road that goes into a block of flats."

Mr Jung did not see Mr Rigg again.

113. Witness A's recall regarding the arrival of the police van is that she saw the police van and flagged it down. She spoke with the driver to describe Mr Rigg and inform him that he had entered Weir Road with Mr Jung following him. She then says that the police van stopped in Weir Road next to Mr Rigg and directly opposite the entrance to the Weir Road Estate.

114. Witness A then states,

"Before the officers had even exited the van, Male A ran off into the Weir Estate. I saw four or five officers jump out of the van."

She goes on to say that,

"They gave chase and followed Male A into the Weir Estate, followed by Liam."

115. Witness A decided to continue along Atkins Road that runs

alongside the rear of the Weir Estate. She did this so that if Mr Rigg ran in her direction she would be able to let the police know.

116. Witness A states that,

"As I was walking past the estate buildings on my left I see the police running through the estate. 30 – 40 seconds after the police gave chase I came to a gap between the buildings from which point I could see two officers bending down. Although I could not see him I assumed that they had detained Male A.

Scene of arrest

117. Mr Rigg was arrested on a grassy quadrangle surrounded by four blocks of flats just off Weir Road.

118. PC Forward was the first police officer to physically encounter Mr Rigg. He provided a witness statement on 22 August 2008 and was interviewed by investigators from the IPCC on 26 January 2009 and 18 March 2009.

119. In his statement, PC Forward says that,

"We got out of the van and asked RIGG to stop. He ran into the nearby estate and he jumped over a fence. I gave chase and after 30 meters he jumped over another fence, and I followed him. As I cleared the second fence RIGG had turned around, in a fighting stance, and as I landed he moved towards me and we fell to the floor. As we fell I grabbed both his arms in my hands so he would not hit me. He managed to get his right arm free and stuck [sic] *me twice with a close* [sic] *fist."*

120. In his interview of 18 March 2008, he expands significantly on his account. PC Forward describes how the police van passed Mr Rigg and parked up. PC Harratt opens the side door and at the same time Mr Rigg runs across Weir Road into Neville Court. The officers then give chase with PC Harratt in front, followed by PC Forward. Mr Rigg then approaches and jumps over a chain link fence approximately 1.5 to 2 metres high. By this time PC Forward is now in front of PC Harratt. PC Forward also jumps over the fence but gets slightly caught up in the chain link that delays him for a few seconds. After PC Forward negotiates the fence he continues to pursue Mr Rigg and shouts "stop police". Mr Rigg continues to run and jumps over another fence about 1 metre in height. As PC Forward jumps this fence he says that Mr Rigg stops, turns around and faces him. Mr Rigg takes on a sideways stance with his left foot forward and his hands clenched and raised. As PC Forward lands, Mr Rigg jumps towards him, and tries to hit him. PC Forward grabs both his wrists and they fall to the floor. They then roll around on the grass with PC Forward still holding Mr Rigg's wrists and Mr Rigg

attempting to hit PC Forward. Mr Rigg attempts to bite PC Forward's right wrist. PC Forward decides that he needs to radio for urgent assistance. He releases Mr Rigg's right hand and attempts to use his personal radio to call for help. At this point Mr Rigg hit PC Forward twice over the head. PC Forward immediately grabs hold of his wrist again to prevent him being struck further. Mr Rigg now has PC Forward pinned to the ground. At this point PC Forward looks to the right and sees PC Harratt jump over the fence and immediately attempt to handcuff Mr Rigg. PC Forward says that PC Harratt handcuffed Mr Rigg's left wrist that was being held by PC Forward. PC Harratt pulled Mr Rigg's arm behind his back, at which point PC Forward was able to free himself from underneath Mr Rigg. Mr Rigg is still struggling and kicking out, and both officers are now attempting to get his right arm from underneath him to put on the handcuffs. Mr Rigg's left arm is still secure and being held behind his back. The two other officers PC Glasson and PC Birks now arrive to assist. Mr Rigg is still resisting and kicking out, and so at this point PC Forward attempts to secure his legs by laying on top of both of them, and holding them together by putting one arm underneath his legs and one over the top. PC Forward then saw a piece of metal sticking out of one of Mr Rigg's shoes. At this point he believes it to be a razor blade. PC Forward removes Mr Rigg's shoes and informs his colleagues about what he believes he has found and advises them to search Mr Rigg. PC Forward then arrests Mr Rigg for assaulting a police officer and cautions him. PC Forward says that throughout this whole time, Mr Rigg says nothing, but he forms the opinion that he does understand. PC Harratt searches Mr Rigg and finds a passport that he believes contains a photograph that does not resemble Mr Rigg and therefore he also arrests him for theft. PC Birks leaves to get the van and parked it at the closest point available that enabled pedestrian access to get Mr Rigg to it. PC Forward then recalls that PC Harratt instructs Mr Rigg on how to safely stand up. Mr Rigg follows these instructions.

121. As mentioned previously in this report, the account of the officers' interaction with Mr Rigg immediately following his arrest and through to Mr Rigg being placed in the police van was covered in the January interviews carried out under a criminal caution.

122. PC Forward was interviewed under a criminal caution on 26 January 2009. In this interview he recounts that they escorted Mr Rigg to the police van with PC Harratt and PC Glasson having control of him by each holding one arm with PC Forward walking behind carrying his shoes. PC Forward describes Mr Rigg as resisting by walking slightly slower than the officers escorting him and therefore his body was at a slight diagonal angle with his legs behind, but he was still walking. On arrival at the police van, PC Birks opened the van door and PC Glasson and PC Harratt assisted Mr Rigg to walk up the steps to get into the van. On entering the van Mr Rigg "glanced" his head on the roof of the van.

123. PC Harratt provided a witness statement on 22 August 2008. He states that when they arrived to where Mr Rigg was,

"We asked him to stop so that we talk [sic] *to him about the offences alleged, he then ran away and we gave chase. We ran into the near by estate where the man hurdled over two fences. He then left my sight for approximately 30 seconds. When I caught up with the suspect he was on top of PC FORWARD and hit him twice to the head. I approached withdrew my handcuffs and placed one on his left wrist applying a compliance technique to his wrist shouting, "Stop resisting." PC FORWARD got free from under the suspect and the suspect fell onto his right arm. At this point, PC BIRKE* [sic] *and PC GLASSON arrived. The suspect was then successfully handcuffed in a rear stack and restrained placed in the police van and conveyed to BRIXTON POLICE STATION."*

124. PC Harratt was also interviewed on 26 March 2009. He describes

how he saw Mr Rigg in the distance and so they pulled the van over. PC Harratt shouted to him words to the effect of “hang on” to which Mr Rigg responded by turning around and running. PC Harratt gave chase and moments later he recalled PC Forward running past him also in pursuit of Mr Rigg. Mr Rigg jumped over two fences, and at about this point PC Harratt lost sight of him for about 10 seconds. When he regained sight of Mr Rigg he was on top of PC Forward. PC Harratt then saw Mr Rigg hit PC Forward twice. PC Harratt attempted to handcuff Mr Rigg behind his back, and during the course of attempting this, Mr Rigg fell with his right arm tucked underneath him. PC Harratt instructed Mr Rigg to free his right arm from under his body, but received no response. PC Harratt states that it took all four officers to restrain Mr Rigg and eventually handcuff him in the rear stack position. PC Harratt says that during the restraining of Mr Rigg, he was kneeling on the right side of him as he lay on the floor, near his head. PC Glasson was on the other side of Mr Rigg by his head and PC Birks and PC Forward were trying to control the lower part of his body. Once Mr Rigg was under control, PC Birks returned to the police van to bring it closer. PC Harratt believed that no injuries were sustained by Mr Rigg or any of the officers during the arrest, except those received by PC Forward following the blows to his head. PC Harratt searched Mr Rigg and found a passport which, in the opinion of PC Harratt, contained a photograph that did not resemble him. He was then arrested for theft of a passport.

125. In his interview of 19 January 2009, which was carried out under a criminal caution, PC Harratt says that once Mr Rigg got to his feet they walked him approximately 20 metres to where the police van was now parked. PC Harratt was holding one arm and PC Glasson the other. On arrival at the van PC Birks opened the rear doors, PC Glasson was holding Mr Rigg’s left arm and PC Harratt holding his right. Mr Rigg walked up the two steps to enter the van, and they

assisted him by maintaining hold of his arm to ensure he didn't fall. He entered the cage area in the back of the van and sat down.

126. PC Birks was the driver of the police van on 21 August. He provided a statement on 22 August and was also interviewed on 21 January 2009 and 18 March 2009.

127. In his statement he describes his encounter with Mr Rigg as follows,

"As I turned onto Weir Road I saw the male matching the description and drove past him and then turned into the junction of Radbourne Road where I stopped the van as [sic] *across the path of the pavement as if to cut him off. I then heard my colleagues shout that the male was running off and saw him run across the road and into the Weir Estate. I followed, having secured the van and eventually found the male with PC FORWARD and PC HABBART* [sic] *holding him on the floor. They had placed one hand in the handcuffs and were struggling to put the other hand into the handcuffs. I helped to secure the 'loose' hand and then once he had been detained I went and collected the van and brought it closer to the location of the detained male [RIGG]. RIGG was then escorted to the van and placed inside".*

128. In his interview of 18 March, PC Birks says that as he saw Mr Rigg, he drove past him, and he then heard a shout from one of his colleagues saying that he was running. PC Birks immediately stopped the van and he was the last officer to exit the vehicle. He secured the van and then ran to assist his colleagues in the pursuit of Mr Rigg. PC Birks was the last to arrive at the scene of the arrest. On his arrival he saw Mr Rigg on the ground with his three colleagues attempting to handcuff him. He assisted his colleagues by bringing Mr Rigg's left arm around to enable the handcuff to be put on. This was the only interaction PC Birks had with Mr Rigg. Once Mr Rigg was secure, PC Birks left to collect the police van.

129. During the interview under caution of 21 January, PC Birks states how he opened the van and cage doors for Mr Rigg to enter. He says that PC Glasson and PC Harratt were assisting Mr Rigg by holding one arm each when Mr Rigg stepped up into the van. PC Birks described Mr Rigg's demeanour as quiet.

130. PC Glasson was the fourth officer involved with the arrest of Mr Rigg. He was interviewed on 22 January 2009, under criminal caution, and 26 March 2009.

131. In his interview of 26 March 2009, PC Glasson states that as they drove into Weir Road he saw Mr Rigg about 20 – 30 metres away. When the police van came to a halt, Mr Rigg was within 10 metres of them. He then ran across the road and the officers gave chase. PC Glasson gave chase and when he came round the side of the building by the grass area where Mr Rigg was apprehended, he saw Mr Rigg lying on the floor. PC Forward and PC Harratt were struggling in their attempts to get his second wrist into the handcuffs, and so PC Glasson joined them to assist. Moments later PC Birks arrived. He says that as Mr Rigg was resisting, it took all four of them to control him in order to put the handcuffs on. Mr Rigg was resisting with his arm in order to prevent the handcuff being put on. PC Glasson describes how he and PC Harratt were at the upper part of Mr Rigg's body and PC Forward and PC Birks were trying to control his legs. When the handcuffs were on, PC Glasson took control of the upper part of Mr Rigg's body by controlling the handcuffs in order to ensure that Mr Rigg did not resist. PC Glasson says that Mr Rigg was searched for weapons and his shoes were removed for safety reasons as there was something metal sticking out of them. PC Glasson says that Mr Rigg did gradually calm down but he still required controlling. He says that at that stage he had no concerns about Mr Rigg's health and did not consider calling for an ambulance. PC Glasson says that he seemed healthy and his breathing was fine. PC Glasson was not aware of any injuries

sustained by Mr Rigg during his arrest and restraint. He was later made aware that Mr Rigg had bumped his head on the van as he was entering but did not notice this at the time.

132. During his interview under caution on 22 January, PC Glasson states how once Mr Rigg was under control, PC Birks went to bring the police van closer for ease of transportation. They assisted Mr Rigg to his feet and walked him to the van. PC Glasson says that he had hold of one of Mr Rigg's arms, and PC Forward had the other with PC Harratt walking behind (in the subsequent interview he clarifies that he got PC Harratt and PC Forward mixed up and it was actually PC Forward bringing up the rear). Mr Rigg was slightly resisting, leaning back, but with a little pressure they were able to walk him to the van and lead him up the steps into the van.

133. The scene of the arrest is a grassy quadrangle situated with blocks of flats on four sides. It is a communal area open to the public and can be used as a cut through on the estate. This site is overlooked by several dozen flats whose rear aspects look out onto this green.

134. This investigation has identified 11 independent witnesses who saw various parts of the police interaction with Mr Rigg at the scene of his arrest. However, there have been no witnesses that saw the initial part of the arrest, and the initial altercation between Mr Rigg and PC Forward.

135. Ms Katherine Leach is a local resident who says that the part of the incident that she witnessed lasted for about 10 minutes. In her statement of 8 September 2008, she says that she initially saw,

"…a male face down with his hands behind his back and his legs out flat and there were four police officers all kneeling around him".

Ms Leach also recalls that,

"Two of the officers were on either side of his torso and they looked

like they were trying to restrain his arms and put handcuffs on. The other two officers were restraining the male's legs and lower half. So there was one officer on ether side of his legs. The male seemed to be struggling. The struggling did not appear to (be) *particularly violent but when the officers took pressure off of his legs he would try to kick out".*

"I could see the male's head but I cannot recall whether it was moving. However, I did not see the officers restrain his head. The next point I remember there were three officers present. One officer was lying across the male's ankles and lower legs. The male's legs were out straight and together".

136. Ms Leach remembers that at one moment Mr Rigg was wearing his shoes, but then a minute later they were off and had been placed on the ground to the side of Mr Rigg.

137. Ms Leach then goes on to describes how Mr Rigg got to his feet. She says,

"When the fourth police officer walked over to the male on the floor the officers picked the male up. The male still seemed to be struggling by not co-operating when he was being lifted up".

"Two officers were holding the male's shoulders and arms and pulled him up to his knees. Then he was just kneeling and his legs were not kicking out. He was only kneeling for seconds before they pulled him up. I recall the officers almost had to push his legs under him as he was not co-operating".

"There were still two officers holding the male's arms at this point with the other two close by. The male was walking by himself but at a slower than average pace".

138. Ms Leach finishes by saying that,

"During the incident I did not see any injuries to the male and I did not see the officers use any implements or their baton. I did not see the officers strike the male at any point".

139. Ms Claire Harris was in the area of the Weir Estate at the time of Mr Rigg's arrest. When she first saw Mr Rigg she said that she believed that he was being arrested. Ms Harris saw four or five male police officers on the grassy area outside the flats with Mr Rigg.

140. Ms Harris says that Mr Rigg was lying down and,

"The man was on the floor with his face down and there were police around his body restraining him. At one point they were holding his feet"

"I can recall that they did not use any implements to restrain him. They also did not appear to be using any excessive force, because he was struggling and was not cooperating".

141. Ms Harris only briefly describes how Mr Rigg got to his feet and travelled to the police van. She says,

"I cannot recall exactly how it happened but the man was on his feet with a policeman on either side of him holding his arms. He was then walked across the grass…"

"Whilst the man had an officer on each side, he was walking by himself and was not being dragged".

142. Ms Sherry White was a witness who made her observations from her stationary car parked on the Weir Estate. She says,

"…I became aware of a male running in the direction of my car".

She goes on to say,

"…he turned right into the gardens at the rear of Olding House"

"As the male was turning into the car parking bay I saw four or five uniformed police officers jumping over a high wire fence …" "I would estimate that these officers were five or six seconds behind the male, and I didn't believe they would catch him. I did not see the male jump over the fence but I assume this is the route he took as the police officers appeared to be following him".

Ms White did not see the man or the officers again.

143. Mr John Williamson lives on the Weir Estate and was first alerted to the incident when he heard shouting outside his flat. He heard someone shout words to the effect of, *"keep still, stay down, don't move".* He then looked out onto the grass area where he saw,

"…a person being held face down with a police officer holding his ankles with another officer, or maybe 2 officers holding his hands behind his back."

144. Mr Williamson only watched the unfolding events for two to three minutes and then went back inside. Moments later he heard someone shout, *"we are getting you up now, we're getting you up now."* Mr Williamson then looked back outside and he,

"…saw that the officers were holding him up, with an officer on either side holding the tops of his arms. They did not seem to be pushing or pulling him".

145. Mr Williamson states that he,

"…never saw the officers use any unnecessary force during the incident."

146. Witness B became aware of the incident when her husband called her to the window to see what was going on. She saw a man lying on the grass face down. She says in her statement of 4 December 2008, that,

"There was one officer by his feet, one holding his hands behind his back. Another officer was holding the man on the back of his neck restraining him. A fourth officer, a stocky one, left and he seemed to go and get the van".

She goes on to say that she,

"…saw the officers take his shoes off and search them and they also searched his pockets."

147. Witness B said that she thought this went on for about 10 to 20 minutes. She also comments that,

"As he was held down he didn't shout and when they took him to the van he wasn't shouting or putting up any fuss."

148. Mr James Duggan is a local resident whose recollection of the incident is as follows,

"…I saw three male police officers in uniform, with short sleeved white shirts holding a male with dark short hair on the green."

"The male was lying face down on the ground."

"The male appeared to be struggling a bit in that he was trying to wriggle his shoulders but he was not able to move much due to the three officers all holding him. One officer was holding his feet and kneeling down. The other two officers were sort of kneeling and lying on the male at his sides to hold him down. At this point I do not think the male was handcuffed as I could see his elbows and arms moving slightly. From my view it just looked like the officers were trying to hold the male securely in this position. I did not see the officers using any violence."

149. Mr Shuber Mauhith saw some of the incident at the scene of the arrest. In his statement of 21 February 2009, he says,

"I cannot recall exactly but there was an officer lying on the male's legs, one had his elbow on the back of the male's neck and the other was holding the male's back. The male was face down on the floor. About 4 – 5 mins later they picked the male up. The officers then walked the male towards the middle of the green. The male did not seem to be struggling".

"I cannot recall how they put him in the van but I do not recall the male struggling or the police using force."

150. Mr Arif Mauhith, brother of Shuber, said that when he looked out from his balcony he could,

"…see 3 officers on top of a male and a 4th officer using his radio."

"There was one officer with an elbow on the back of the male's neck, one officer with his knee on the males back and one officer lying on the male's legs. After a few minutes they put handcuffs on the male. The male was face down and handcuffed to the rear. After a few more minutes they picked the male up and began to walk him towards the middle of the green..."

151. Regarding how Mr Rigg got to the police van, Mr Mauhith says,

"…the male was not struggling and was walking on his own just being held on either side on his arms."

152. Once Mr Rigg was in the van, Mr Mauhith says,

"I can recall that the van was shaking a little bit when the officers were in the van with him, I did not hear any noise at all."

153. Mr Abdul Mauhith is the third member of the family to provide a witness statement. His account of what happens states,

"The officers were restraining a male on the floor. I think at this point they were putting on handcuffs. About 2 - 4 minutes later they

got up and helped the male up and began to walk him through the centre of the green…"

"The male was walking on his own with the officers holding his arms which were cuffed behind his back. I watched the police take him round the corner. I did not see the police use any force when they walked him."

154. Mr Mauhith saw the officers put Mr Rigg in the back of the police van and says that, *"The male did not struggle and was not shouting."* Once Mr Rigg was in the van, Mr Mauhith says,

"The van then remained there for a few minutes. During this time the van was shaking a bit but I could not hear anything."

155. The nine witnesses, whose accounts have been précised above, all give a broadly similar description of what happened regarding Mr Rigg's arrest on the Weir Estate.

156. There were two other independent witnesses who recalled a different version of events when interviewed by the IPCC.

157. Witness C is a resident on the Weir Estate who gave her statement on 12 November 2008. She says that her attention was initially drawn to the area outside her flat because she heard shouting. Witness C heard someone say, "we've got him", and she was worried because she thought it might have something to do with her nephew as he was playing outside.

158. Witness C went to her balcony and stayed there for about 10 minutes, but her view was obscured by a tree. Eventually she says she,

"…saw a male being escorted by 3 police officers from the top left of the green as I look from my balcony. The male's trousers were low showing his underwear. He was also handcuffed to the back and an

officer who was chubby had his hand hooked underneath the handcuffs. The other two officers were walking by side".

159. Witness C's account then starts to vary from the other witnesses. She says,

"When they reached the pathway I saw the male trip on a piece of concrete that was sticking up…"

"When the male tripped he fell face down but his head was turned to the left".

160. Witness C goes on to say,

"The chubby officer knelt down on the males [sic] *I could not tell whether they were talking at this point. The other two officers were still standing at the side of him the male was on the floor for 5-10 mins, during this time I could not hear anything. All three officers then lifted the male up like a rag doll. The chubby officer had his hand under the handcuffs and the two other officers were on the side and were also lifting him up by his handcuffed hands. The officers on the side were holding the side of the male's hands. By doing this they dragged him up to his feet. The male then was standing on his feet supporting his own weight. Around this point the male was saying, "what have I done, what have I done?" and looked shocked. The short muscular officer said a word I cannot recall but he was telling him why he had been arrested. At this point the chubby officer starting* [sic] *hitting the male with the white plimsolls across the back of the head just above the neck. He hit him about 3 or 4 times. I could hear the hits and they appeared to be hard hits. The officer was using his right hand to hit him with both shoes which he had held by hooking his fingers in the back of the shoe. I could see that the male was in pain and he had a tear in his right eye. The other two officers were just standing to either side of the male. At this point I saw a police van travelling past Olding*

House inside the estate up the side of Jewell House. It was a marked transit van. About 5 secs later 3 other officers came round from the car park to my right as I look out of the back balcony. At this point the male was saying, "It is hurting". The police responded but I can't recall what they said. When the three other officers reached the male I think the male may have (been) *scared and was trying* (to) *back off so he could get away. I think the male was saying something but I couldn't hear it. I think there were words being exchanged. The next thing I recall is the officers were holding him horizontally off the ground like a battering ram".*

161. Witness C then describes who and how Mr Rigg was being held. She says,

"Two of the officers who had come around from the van were on each leg. The chubby officer was still holding him under the handcuffs standing to the male's right holding the male's handcuffs with his left hand. The Geordie officer was on the left hand side holding the side of the male. A baby faced officer who had come from the van was also in the left holding the male's shoulder, the short muscular officer was holding the male on the right pulling the male's shoulder back. They then walked around with the male in the battering ram position".

162. Witness C then lost sight of the officers and Mr Rigg until she changed her position to gain a view of the police van. She recalls that,

"I could see the male was still being held like a battering ram and 4 officers threw him into the van. This was the 4 officers who were holding the top half the two officers who were holding the legs let go and stood back. The four officers threw him into the van, when the officers let go he flew through the air and landed in the van. I could see this from my view point but I could not see into the back of the

van. The male was shouting angrily, "it hurts, it hurts, it hurts".

163. Witness C made a second statement on 7 January 2009. In this second statement Witness C's recollection is slightly different on a couple of points. Regarding the alleged assault of Mr Rigg with his shoes she says,

"…I saw an officer hitting the male with shoes. This was just after he had been pulled up after he tripped".

"I think they hit him more than 20 times. It was not really hard but was like slapping his back. I could hear the slapping noise. The shoes were plimsolls".

164. Ms Violet McDill also saw the altercation between Mr Rigg and the police officers. In her statement she has numbered the officers for ease of identification. Ms McDill says,

"When I first looked out of the window I saw officers 1 and 2 on the green just in front of the parking bay and the railings".

I also saw a leg hanging down from the big tree on the left…(the leg) *belonged to the male in the beige trousers."*

165. Ms McDill also states that,

"I saw officer 1 pull the male by his ankle. I believe officer 1 was pulling the male's ankle for about 5 minutes so I presume the male was holding onto something".

"After this time the male fell out of the tree and landed on his right hand side with his back to me…"

"As the male hit the ground I heard a thud which I believe was his head, as I saw it hitting the ground".

166. She describes the rest of the incident as follows,

"When the male landed on the ground officers 1 and 3 turned the male onto his back by rolling him. Officer 1 had taken hold of the male's ankles with both hands and officer 3 had hold of both of the male's shoulders. Officer 1was kneeling on both knees to the male's right hand side facing Olding House. Officer 3 was on one knee behind and to the left-hand side of the male, pinning the male down by his shoulders so that he could not get up. Officer 2 was kneeling on one knee to the right-hand side of the male, level with his waist. Officer 2 punched the male with a closed right fist to the male's chest area, in the middle. I think officer 2 punched the male four times, and with each punch I heard the male moan in pain. In punching the male the officer pulled his right elbow back at shoulder height and then moved it with what looked like a lot of force in a downwards direction until it reached the male's chest".

167. Ms McDill believes that Mr Rigg was held down on the ground by the police officers for approximately 30 minutes.

Transportation to Brixton Police Station

168. Mr Rigg is placed in the cage area in the back of the van. Access can be obtained to this cage area from both the outside rear van doors and from within the van itself.

169. Once in the police van, the officers transport Mr Rigg to Brixton Police Station. The journey to the police station is just over two miles and took just a matter of minutes to complete.

170. All four of the officers involved with the arrest of Mr Rigg travelled back to the police station in the van. PC Birks drove with PC Glasson in the front passenger seat. PC Forward and PC Harratt

were situated in the rear of the van where they were able to monitor Mr Rigg.

171. Of the officers who made initial statements, only PC Birks made mention of the journey back to the police station. He says,

“On route back to Brixton I made progress to the Custody Suite as I could see and hear RIGG moving around inside the van”.

172. During their interviews in March, the officers were asked to provide accounts of the trip back to Brixton Police Station.

173. During his interview of 18 March, PC Forward said that when Mr Rigg got into the van he initially sat on the bench in the cage area. He still had his hands cuffed behind his back. As PC Forward entered the van to take up his position in the rear facing seats in the back, Mr Rigg then got on the floor and started to spin round on his back using his feet to walk around the sides of the cage area. At this point PC Forward arrested Mr Rigg for Section 4 Public Order relating to his behaviour as described by the members of the public before the police arrived on the scene. PC Forward asked Mr Rigg what his name was and whether he was alright. He also asked him to sit back on the bench because he believed that Mr Rigg would have hurt his wrists through the pressure being exerted on his handcuffs. Mr Rigg gave no response, although he did periodically look at the officers when they were speaking to him. He made the occasional growling noise and continued to spin.

174. PC Harratt was interviewed on 26 March. He stated in this interview that as soon as Mr Rigg entered the cage area in the back of the van he sat on the floor and started to kick his legs. Mr Rigg was then on his back with his feet on the walls of the cage. He then began to run around the walls of the cage, whilst on his back. PC Harratt says that Mr Rigg didn’t say anything during the course of the journey.

175. In his interview of the 18 March, PC Birks simply states that from his position in the driver's seat he could sense that Mr Rigg was moving around. He also did not hear Mr Rigg say anything throughout the course of the journey.

176. PC Glasson, when interviewed on 26 March, recalled the journey back to the police station similarly to the other officers. He said that Mr Rigg was put on the seat in the cage, but then slid down onto the floor. Mr Rigg was moving about on his back with his legs on the walls. As PC Glasson was sitting in the front passenger seat of the van, he was unable to monitor Mr Rigg's movements. He did not

recall Mr Rigg saying anything, nor did he hear any shouting coming from the back.

Brixton Police Station

177. According to the Brixton police station CCTV the police van containing Mr Rigg arrived in the back yard of the police station at 7.53pm.

178. The van reverses into a parking bay in line with all the other parked vehicles in the yard. The rear of the van was now at right angles to the door of the cage area and several yards from it.

179. The cage area is a secure holding area that leads to the custody suite. It is often used as a secure waiting area for detained persons to be kept until the custody officer is in a position to be able to receive them.

180. As soon as the van is parked, an officer can be seen on the CCTV to alight at 7.54pm, and enter the custody area. This officer was PC Birks.

181. PC Birks approached the custody desk at 7.55pm, where he spoke to the custody sergeant to inform him that they had a detainee in the van outside, and to also notify him that PC Forward had been assaulted.

182. The custody sergeant, PS White, told PC Birks that there was a queue and they would have to wait. He told PC Birks to keep Mr Rigg in the van until the custody suite was clearer. This would enable the custody sergeant to receive Mr Rigg securely.

183. One minute later at 7.56pm, PC Birks leaves the custody area and returns to the van.

184. The other three officers got out of the vehicle while PC Birks enters

the custody area, and they stay at the van by the rear doors. They open the rear doors for ease of monitoring Mr Rigg, and to also allow fresh air to circulate.

185. PC Glasson says that when they opened the rear doors Mr Rigg was still on the floor moving himself around with his legs on the wall. PC Forward adds to this that even though the rear van doors were open, the van cage door was not.

186. Sgt Andrew Dunn was on duty as Section Sergeant at Brixton police station on 21 August. He recalls in his statement of 5 January 2009, that he was passing through the custody area when he met PC Birks. PC Birks informed Sgt Dunn that one of the new officers had been assaulted. This was the second time in two days, as he had also been assaulted the previous evening.

187. As part of his duties, Sgt Dunn went out into the yard to check on the welfare of the officer who had been assaulted. Sgt Dunn states,

"This officer, and possibly two others, was stood at the rear of the transport van, the rear doors were open but the Perspex inner door closed. I glanced at the occupant, who I now know to have been Sean RIGG, and saw he was sat with his back against the driver's side of the van. I cannot remember exactly what he was doing, certainly nothing that drew my attention to him. I do not remember any shouting, screaming or the van rocking, which sometimes happens and would remain a memorable event in my mind. I only glanced at him as to continue to look can sometimes have the effect of aggravating people. This again reinforces my belief that he was not acting in a way which caused me any concern".

188. PS White also went to check on Mr Rigg in the back of the van. When he arrived, Mr Rigg was sitting on the bench on the right hand side. PS White spoke to Mr Rigg and had eye contact with him. He satisfied himself that Mr Rigg was conscious and that there was

nothing he needed to do with regard to the immediate care of Mr Rigg.

189. Just after 8pm the cage area became vacant. PC Birks made the decision to move Mr Rigg into the empty cage area in order to free up the van to answer any other calls for which it may be required.

190. At 8.03pm, Mr Rigg leaves the van and enters this cage area. He is assisted by two officers, one holding each arm. On the CCTV Mr Rigg can be seen to be moving his legs and walking the few yards from the van to the cage. He also appears to receive considerable assistance from the two officers.

191. PC Birks said how he felt there was nothing untoward in Mr Rigg's demeanour when he exited the van. He said he thought that Mr Rigg was cold to the touch, but he walked over to the cage area of his own free will. PC Birks explained to Mr Rigg what was happening, but he received no response from him.

192. PC Harratt recalls that Mr Rigg walked into the cage on his own, with him on one side and PC Anthony Owen on the other. However, PC Owen has no recollection of this and states that he only became involved when Mr Rigg was in the custody cage area.

193. At 8.04pm, Mr Rigg can be seen to be sitting in the corner of the cage area with his legs straight, facing along the corridor into the custody area.

194. During the next two and a half minutes, Mr Rigg occasionally flexes his legs and then straightens them. He then lies down with his head at the far end of the cage with his back to the custody area.

195. At 8.06pm the custody officer, PS White, enters the cage area and stands over Mr Rigg for about 30 seconds before moving away.

196. Speaking about this check on Mr Rigg, PS White recalls in his

interview that at some point he walked over to the cage area to check on him. He saw him lying on his side with his hands cuffed to the rear. PS White describes him as being in the “semi foetal position” with his head furthest away from the cage door.

197. PS White explained how it is more concerning if a prisoner is brought in, and is not standing up. He asked Mr Rigg to open and close his eyes, which he did on command. In PS White’s opinion, Mr Rigg showed a high level of response. PS White was also mindful of a condition known as excited delirium and therefore felt Mr Rigg’s skin to check his temperature. He said that his skin felt normal and therefore he was content that it was not excited delirium as he believed that this was always accompanied by an increased body temperature.

198. PS White then notified the Forensic Medical Examiner (FME) of Mr Rigg’s condition and continued with his duties.

199. At about this time, PC Anthony Owen was approached by PS White and asked to stand with the two officers in the cage as they were new to the job and the sergeant anticipated that there would be a wait until he would be ready to book in Mr Rigg.

200. PC Owen says in his statement dated 12 February 2009,

“Whilst I was stood with them RIGG was sat on the floor handcuffed to the rear. He suddenly started to stand up. He managed to stand and appeared unsteady on his feet so I held him up in the corner so that he did not fall over. Suddenly RIGG urinated in his trousers and his legs went so he fell to the floor as a dead weight. RIGG was placed in the recovery position and the FME was called for.

201. The custody CCTV supports PC Owen’s recollection in that at approximately 8.10pm, Mr Rigg can be seen on the CCTV to stand against the wall of the cage supported by two officers. He then

bends at the waist, goes down on his knees and moments later lies on the floor of the cage.

202. Seconds later, at 8.12pm, the custody officer arrives, and one minute after that the FME arrives to attend to Mr Rigg.

203. PC Owen says that,

"The FME came and assessed RIGG and stated that his breathing was okay but that an ambulance should be called for."

204. The FME, Dr Nandasena Amarasekera, provided a statement on 14 October 2008. On arriving to see Mr Rigg he recalls,

"I could see that the male's right arm was straight and outstretched from his body in front of him and his left arm was lying on his left leg in line with his body. The right side of the male's face was touching the floor and I noticed that his trousers were wet which made me think that the male had lost control of his bladder. There were approximately 2 or 3 uniformed police officers standing and crouching around the male attending to him by talking to him…"

205. Dr Amarasekera attended to Mr Rigg for several minutes. He states that,

"I bent over the male and carried out a number of checks on him in what order I cannot remember as I have done this so many times it is automatic to me. But I checked the man's wrist which one I cannot remember and his pulse was around 90 beats per minute which was fast but not unusual in situations like this. I used my stethoscope on his chest to listen to his heart sounds and his breathing rate was about 18 breathes per minute which is quite rapid. Whilst I was doing this I noticed that the male's body was warm and as the cage floor is cold I asked for a blanket so that he would not get cold. I asked the male to open his eyes which he did and his eyes looked fine they were not dilated or fixed."

206. At 8.16pm, the FME leaves Mr Rigg, and moments later a blanket is passed into the cage for Mr Rigg.

207. Also at 8.16pm according to CAD 8289, an ambulance was called for Mr Rigg.

208. PC Owen says that after the ambulance was called he,

"…monitored RIGGs condition while we waited. I could see he was breathing through the fact that his back was rising and falling and I could hear breath sounds from him. A short time later RIGGs breathing appeared to slow and I called for the FME to come out again. The FME took a short while and I called more urgently for the FME. He came out and assessed RIGG again.

209. When the FME arrived to assess Mr Rigg for the second time he,

"…checked the male's pulse and breathing and there was no chest movement. A police officer then started to do mouth to mouth resuscitation and they took it in turns to do this".

He goes on to say that,

"They brought with them a defibrillator which they used about 5 – 6 times on the male".

210. Following the return of Dr Amarasekera, PC Owen recalls that the Dr checked on Mr Rigg and,

"As he (Dr Amarasekera) *stood up he turned to me and my colleague PC BURKES* [sic] *and told us that RIGGS heart had stopped. I exclaimed "what!!". The FME then said again that RIGGS heart had stopped beating. I immediately shouted loudly "DEFIB " (calling for the automated defibrillator kept in custody). Myself and the other officers present got down to commence CPR on RIGG. RIGG was placed on his back and I commenced chest*

compressions. I was aware that the FME left us to deal with RIGG and disappeared up the corridor behind us into the custody suite. I believe it was PS WHITE that ran the defib out to us. PC BURKES cut clothing away and took responsibility for the use of the defib. We commenced CPR and I was aware that various other officers appeared and began to sort out what needed to be done. I heard that a message was being passed to the London ambulance service that CPR had been commenced on the patient they were attending for, but my main concentration was focused on RIGGS CPR.

211. PS White said in his interview that he heard the call for a defibrillator as he was sitting at his desk in the custody area. He immediately grabbed the defibrillator and ran to the cage. PS White also said that he was confident in PC Birks' ability to manage the situation as he had done some defibrillator training with him in the past.

212. The four officers involved in Mr Rigg's arrest gave an account of their recollections of what happened in the cage during their misconduct interviews in March 2009.

213. During his interview on 18 March, PC Birks says that while they were waiting in the cage, Mr Rigg did not say anything and kept trying to sit down. PC Birks decided that it would be safer for Mr Rigg to sit on the floor as he would have less opportunity to hit out at the officers.

214. PC Birks also says that at some point, Mr Rigg stood up of his own accord and began to urinate. He looked at Mr Rigg to assess whether Mr Rigg was ill or merely faking. Without any warning Mr Rigg then collapsed onto the floor. At this point PC Birks said that he knew Mr Rigg was ill, and he immediately called for the FME.

215. PC Birks recalls that when the FME came, he examined Mr Rigg and said that he needed to be checked out by the hospital. PC Birks says that the FME believed that Mr Rigg had suffered a seizure.

216. PC Birks then immediately called for an ambulance using his radio. PC Birks estimates that the time elapsed from calling for the FME to attend and him calling for an ambulance was less than a minute.

217. PC Birks goes on to say that after the FME left, it soon became apparent to him that things were not right. He called for the FME to return, and when he did, Dr Amarasekera said that Mr Rigg's heart had stopped. PC Birks then shouted for the defibrillator and he managed the Cardio Pulmonary Resuscitation (CPR) for 11 minutes until the ambulance arrived.

218. PC Forward recalls Mr Rigg's time in the cage area as follows. He says that he was called to the custody desk by PS White to give an account of what had happened. PC Forward was in the cage area at the time, and when he left to see the custody sergeant, Mr Rigg was standing up. When he returned, Mr Rigg was sitting on the floor with officers around him, talking to him and asking if he was alright.

219. At some stage Mr Rigg attempted to lie down, but as the floor was concrete the officers did not allow this and so attempted to keep him in a sitting position.

220. PC Forward also recalls that the officers decided to stand him up which they did by holding his arms. While he was standing, PC Forward says that as he was looking at him, he urinated and fell to the floor. Someone then called for the custody sergeant and the FME who both attended to check on him.

221. At this point, PC Forward could see that Mr Rigg was still breathing. The FME asked for a blanket for Mr Rigg and said that he should remain on the floor. PC Forward also recalls that it was at this point his handcuffs were removed and an ambulance called.

222. Shortly after this, the FME was called again and then someone called for a defibrillator. PC Forward performed mouth to mouth on

Mr Rigg, whilst another officer performed chest compressions.

223. PC Glasson says that when they took Mr Rigg into the cage area, he initially stood up but then tried to sit down. Mr Rigg did not ask to sit, but kept trying to slide down the side of the cage. The officers attempted to keep him in the standing position, but eventually allowed him to sit in order to avoid a confrontation.

224. PC Glasson says that he did not believe that Mr Rigg was so ill at this stage that he was trying to collapse. He said that he was breathing fine and when they stood him up his legs seemed strong enough to hold him and his eyes were open.

225. After allowing Mr Rigg to sit down the FME came out to assess him and PS White also tries to talk to him. PC Glasson recalls that the FME came to assess Mr Rigg two or three times. When the FME left Mr Rigg, he began to try to lie down from his seated position. The officers tried to keep him in a seated position as the floor was cold and Mr Rigg was not wearing a shirt.

226. PC Glasson recalls getting Mr Rigg into a semi standing position, at which point he realised that Mr Rigg had urinated himself. Almost immediately, Mr Rigg fell forward from his standing position and passed out. The officers guided him to the ground.

227. The FME returned to examine Mr Rigg. He monitored his breathing and his heart beat and said that both were okay. At this point they took off his handcuffs and put him in the recovery position. By this time the ambulance had already been called.

228. Once Mr Rigg was in the recovery position, PC Glasson and the other officers continued to monitor his breathing. PC Glasson recalls that Mr Rigg’s breathing began to get shallower causing concern that prompted the officers to call for the FME again.

229. When the FME returned, he used his stethoscope and tried to take a

pulse. PC Glasson then says that the FME stood up and said that his heart had stopped. At this point they turned him on his back and began CPR. PC Glasson says that he was involved in the CPR process, but the FME did not take part. PC Glasson adds that he was trained to give CPR but not to use the defibrillator, therefore PC Birks, who was defibrillator trained, took responsibility for this aspect of Mr Rigg's care.

230. PC Harratt was interviewed on 26 March 2009. During his interview he recalled what happened in the cage area as follows.

231. When Mr Rigg entered the cage, he initially stood in the corner and then without saying anything, sat down. From his sitting position, he then lay down with his head at the far end of the cage still without saying anything.

232. PC Harratt recalls that Mr Rigg was initially looking in the direction of the car park, but turned over several times. He was still handcuffed at this stage.

233. PC Harratt remembers that at some stage PS White and the FME came to see Mr Rigg. The FME said that Mr Rigg's breathing, heart and pulse were all fine.

234. Mr Rigg kept moving about in the cage area, as it was a confined space the officers decided to stand him up. PC Harratt was standing to Mr Rigg's left with PC Owen on his right hand side.

235. Mr Rigg slid down to the floor, and once again the officers stood him up. Mr Rigg then urinated himself and flopped to the floor. It was at this stage that PC Harratt became concerned about Mr Rigg's health. PC Harratt also described him as having some sort of fit. This fit was not a violent one, but it appeared that Mr Rigg began to twitch.

236. PC Harratt says that the FME was immediately called again. A

blanket was brought from custody and one of Mr Rigg's handcuffs was removed. The other handcuff bracelet was kept on in case Mr Rigg's condition was not genuine.

237. The FME checked Mr Rigg's heart and breathing and said they were fine. PC Harratt and PC Owen continued to monitor Mr Rigg's breathing visually by checking the rise and fall of his chest.

238. At some point, both PC Harratt and PC Owen noticed that Mr Rigg's back was no longer moving. They both immediately called for the FME. When the FME arrived he said that Mr Rigg's heart had stopped and then someone called for a defibrillator.

239. PC Harratt recalls that by this time Mr Rigg's remaining handcuff had been removed, he had already been put in the recovery position.

240. At 8.19pm, PC Birks used his radio to call for an ambulance to attend the police station for Mr Rigg. This call was recorded on the CAD with reference 3063.

241. On this CAD the operator has recorded under the heading of Special Instructions, "Your attendance please we got a male with mental issues".

242. PC Birks denies in interview that he ever said this and it can be clearly seen from the audio recording of his call that he did not mention anything about mental health issues in his conversation to the ambulance service.

243. The London Ambulance Service (LAS) have been asked to provide an explanation as to how these words could have appeared on the CAD. They have responded by stating that the operator would only type on this part of the CAD what they were being told by the caller. This has been shown not to be the case and the LAS have been unable to supply an alternative explanation.

244. At 8.34pm, PS White called the ambulance service by phone, as the paramedics had not arrived.

245. At 8.35pm, the ambulance did arrive at the police station and one minute later the paramedics enter the cage area to attend to Mr Rigg.

246. Ms Lee Milton was the senior paramedic in the ambulance. She was crewed with student paramedic Mr Declan Tudor-Stewart, and emergency medical technician Mr Simon Griffin.

247. On arrival, the ambulance drove into the police station yard, and Ms Milton comments that,

"As we drove into the police station I saw the cage area with several police officers in it, I did notice that there was a person on the floor of the cage area receiving chest compressions which were being performed by a male police officer who was facing out towards the yard of the police station. Although it was a very brief glimpse before I got out of the ambulance I noticed that there was one police officer at the head end of the person and several other officers in the cage".

248. The paramedics immediately entered the cage area where Ms Milton could immediately see that,

"There was one police officer kneeling down at the head of the male and another police officer performing chest compressions which appeared to be effective as the rate and depth of them were adequate".

249. Ms Milton outlines in her statement of 11 December 2008, the medical procedures undertaken by the paramedics in their attempt to save Mr Rigg's life.

250. At 8.44pm, a second ambulance crew arrive. This crew comprised

Mr Joseph Collins, a paramedic and Mr Alex Batty an emergency medical technician.

251. These medical staff assisted their colleagues in the cage area, and their medical efforts are outlined in their statements of 24 December 2008 and 29 January 2009.

252. At 8.59pm, Mr Rigg is lifted onto a trolley and taken out to the ambulance.

253. At 9.03pm, the ambulance leaves the police station.

254. At approximately 9.09pm, the ambulance arrives at Kings College Hospital.

255. At approximately 9.24pm, Mr Rigg is pronounced dead.

Call handling

Central Communication Command

256. The Metropolitan Police Service Central Communications Command (CCC) is responsible for answering calls from the public, both emergency and non-emergency. They also dispatch police officers to the scene of incidents as and when required. There are three operational centres within the CCC that cover the whole of London. These are at Lambeth, Bow and Hendon. The CCC (through its three centres) takes an average of over 6,000 emergency (999) and over 15,000 non-emergency calls per day.

257. If the call requires a police response, the operator will create a Computer Aided Dispatch (CAD) message. The call is given a 'Type Code', from a set of standard definitions agreed through National Standard of Incident Recording (NSIR). There are a total of 75 type codes covering the various kinds of incidents that the police deal with. The call is then graded and routed to dispatch for deployment,

or to the Borough for other possible resourcing deployments.

258. The grading of the call is the part of the CAD that dictates the type of response that the police will supply.

Integrated Borough Operations

259. Integrated Borough Operations (IBO) were introduced in Lambeth Borough in August 2006. It formed part of a large-scale change programme within the MPS to replace outdated CAD Rooms that were unable to manage the increasing levels of demand. First Contact and call dispatch were transferred to CCC with the IBO maintaining the management of incidents in their borough through enhanced intelligence and resource management.

260. IBOs operate around the clock at Borough level to provide:

- An overview of operational activity, including demand and tasking.
- The management of borough resources and resource information.
- Fast time intelligence.
- An interface between CCC and the Borough.
- Incident ownership and incident command.
- Authority over local units responding to an incident.
- Support and information to local supervisors.

261. The borough owns all CAD incidents - routine, major or critical, as well as command of those incidents. The IBO/borough supervisor's decision as to resourcing or response to a particular incident is final. CCC cannot over-rule such operational decisions. However, the initial deployment of these resources can only be carried out by the CCC.

262. There are five different categories of call grading that can be allocated to any particular 999 call. This grading denotes the type of police response the call handler feels is appropriate based on the

information received.

Immediate Response ‘I’

263. This should result in the immediate deployment of a police response (mobile or foot patrol) who will arrive at the scene in the shortest possible time. The Metropolitan Police Service aim for ‘I’ calls, is to arrive at the incident within 12 minute, 75% of the time. This response is appropriate in the following circumstances:

- Where serious injury to people or damage to property has occurred, or where there is potential for such injury or damage.
- Where a crime is in progress.
- Where a suspect is present, or there is potential for the immediate arrest of an offender.
- Where witnesses or other evidence may be lost if police do not get to the scene quickly.
- Where there is clear potential for further crime.
- Where the caller is suffering extreme distress: such as victim of hate crime, domestic violence or the very young or very old, even though other factors indicate a less immediate response would be warranted.
- Where for any other reason the operator taking the call, considers an immediate response is appropriate.

Soon Response ‘S’

264. With this grade there is a requirement to attend as "soon as possible", and in any case, within an hour. This response would be where police deployment of a less urgent nature is required, and where such a response would not materially affect the outcome.

This response is appropriate in the following circumstances:

- No serious injury has occurred or likely to occur.

- A crime has already occurred and an immediate attendance of an officer would not affect the outcome.
- There are no suspects, no witnesses and no potential loss of witnesses and/or evidence.
- Victims are not in need of immediate help and are not suffering from stress to the extent that they need immediate help or support.

Extended ‘E’

265. An extended response applies where it is known, or believed at the time of the call that attendance will be later than one hour from the time of origin. In these cases a 'loose' or 'firm' appointment time is agreed and a scheduled appointment made on the CAD.

An extended response is appropriate where:

- No resource is available to meet the ‘S’ grade timescale. The caller is informed at the time. It is better that the caller is aware of a delay, rather than expect a "soon" response, and be disappointed at a delay of several hours.
- Where awareness of existing commitments make this the most suitable response.
- Where an appointment is made for officers with particular skills or knowledge, either of the subject matter, complainant or victim.
- In a non-urgent neighbours dispute where other officers have existing knowledge of the parties involved and there are no aggravating circumstances.
- Where the incident is of such a nature that it doesn't warrant a faster response (i.e. collection of property).

Referral ‘R’

266. This category is reserved for calls that do not require a physical police response. Police might still be required to provide advice, or refer to another police department or refer to an outside agency

such as the local authority.

Police Generated ‘P’

267. This refers to calls generated that do not come from the public. These include self-generated incidents where there is no existing CAD.

Re-Grading

268. Once a CAD has been generated and a grade allocated, there is a contingent for this grade to be changed in appropriate circumstances. This action of re-grading is restricted to Borough and/or CCC supervisors. There is a requirement to record the reason for change in the appropriate field of the CAD.

269. In those cases where there is more than one report relating to the same incident, the first CAD that is created should be used as the working CAD, and its relevant grade used to denote the type of police response that is appropriate. All subsequent calls made relating to the same incident should have their CADs graded as ‘R’ and linked to the original working CAD.

CAD6148 (4.53PM)

270. At 4.53pm, Mr Alvares dialled 999 to report the actions of Mr Rigg to the police. The call handler who dealt with Mr Alvares’ call was Ms Yvonne Goulbourne of the Central Communications Command at Lambeth.

271. Mr Alvares explained to Ms Goulbourne that Mr Rigg was a resident at Fairmount Road who suffered from Paranoid Schizophrenia. He said that he believed Mr Rigg had not taken his medication for about a week and was acting in a *“… very threatening and vicious manner”.* Mr Alvares said that when he and his colleague went to

speak to Mr Rigg, he began doing martial arts and advanced towards them as if to strike them. Mr Alvares and his colleague turned and ran. Mr Alvares also told Ms Goulbourne that Mr Rigg had a history of assaulting two police officers and he believed that the staff and residents at the hostel were at risk.

272. After approximately three minutes 30 seconds Mr Alvares handed the phone to Mr Stevens who reiterated what Mr Alvares had already stated. This whole call lasted seven minutes.

273. The main issues of this conversation are fully reflected in the CAD entry made by Ms Goulbourne. She designates this call as an 'S' grade.

At 5.05pm this CAD was annotated by Mr Keith Price, a supervisor at the CCC with, *"This is not a police matter. Staff to deal with Dr's assistance if required".* A minute later at 5.06pm this call was downgraded from an 'S' to an 'R' grade, and the CAD was marked up as, *"no deployment",* again by Mr Price.

274. At 5.09pm, Mr Price called Mr Alvares at the hostel to get an update of the situation. Mr Price was informed that Mr Rigg was now in the front garden and causing a disturbance. As a consequence of this, at 5.10pm, Mr Price upgraded the call back to an 'S' grade, requiring response as soon as possible.

CAD6549 (5.32PM)

275. At 5.32pm, Mr Stevens called the emergency operator to speak to the police again regarding the behaviour of Mr Rigg. The call handler on this occasion was Mr Brett Wainwright from the CCC at Lambeth.

276. During this much shorter call, (it lasted for one minute), Mr Stevens gave the previous CAD reference number and explained he was

calling about one of his service users who was displaying threatening behaviour. He said that Mr Rigg was throwing things around in the garden and he had caused damage to the Project's property, namely garden tables and a gazebo. Mr Stevens explained that Mr Rigg was a severe risk to them and he required an emergency response. He also went on to say that Mr Rigg was at that moment lying on the floor in the garden.

277. Mr Wainwright notified Mr Stevens that there was no-one available to attend at that moment, but he would update the police station.

278. The information that Mr Stevens imparted was accurately recorded on the CAD by Mr Wainwright, and Mr Wainwright concluded that the 'S' grade already allocated to this incident was appropriate.

279. At 5.34pm, Mr Wainwright then linked this CAD to the original CAD 6148. This is the usual practice when a call comes in relating to an ongoing incident.

280. Following receipt of this second 999 call, several attempts were made by the call handlers at the CCC to deploy patrol vehicles to the hostel. These attempts were made by electronically sending the information on the CAD message to the Mobile Data Terminals (MDT) that are mounted in police patrol vehicles.

281. Once this information is sent to the patrol vehicle, it is then up to the officers in that vehicle to reply by pressing a button. If the officers are in a position where they are able to respond to that specific incident, they "accept" the CAD. If they cannot respond, they will "reject" the CAD, and then the CCC will know that they need to attempt to deploy other resources.

282. At 5.35pm, PC Victoria Hartley at the Brixton IBO asked the CCC, via the CAD system, if there was a unit that was available to attend.

283. At 5.39pm, Mr Price sent the CAD containing all the relevant

information, via the MDT to a patrol vehicle with the callsign LD22D.

284. At 5.42pm, a “no answer” was returned via the MDT from LD22D. This type of response means that the CAD was neither accepted nor rejected by the occupants of the patrol vehicle.

285. At 5.45pm, Mr Price again attempted to deploy a unit by this time sending the CAD to the patrol vehicle with the callsign LD23D.

286. At 5.48pm, a “no answer” response came back from this unit.

287. Mr Price sent the CAD again to LD23D at 5.51pm, but again received a no answer response at 5.54pm.

288. Mr Christopher Turner acknowledged the CCC receipt of this no answer response and immediately re-sent the CAD to LD23D at 5.56pm. Another no answer response was received at 5.58pm, and this was immediately acknowledged by another call handler.

289. At 6.01pm, Mr Turner sent the CAD to LD2D, but at 6.04pm a “no answer” response was again received.

290. At 6.05pm, Mr Turner made another attempt to allocate LD23D to the incident. At 6.08pm he again received a “no answer” response.

CAD7311 (6.46PM)

291. At 6.46pm, Mr Stevens dialled 999 again. The call handler on this occasion was Ms Claire Downham from the Lambeth CCC. She was given the CAD reference 6148 and was updated on the current situation by Mr Stevens.

292. Mr Steven informed Ms Downham that when Mr Rigg was outside, he had damaged a lot of property and was threatening. Mr Rigg was now inside the building and they had heard him shout through the floor. Ms Downham asked if Mr Stevens had called a doctor as she said that it appeared that Mr Rigg required a mental health

assessment. Mr Stevens said that he had contacted the duty social worker.

293. Ms Downham asked if Mr Stevens wanted the police to come down to section Mr Rigg. Mr Steven replied that he was not necessarily saying that he wanted the police to section him, but he reiterated that Mr Rigg was a severe risk to everybody in the house.

294. Ms Downham accurately updated the CAD with Mr Steven's information, and at 6.47pm this CAD was linked to the working CAD 6148.

CAD7678 (7.19PM)

295. Ms Wood phoned 999 at 7.19pm, and her call was taken by Mr Michael Coleman at the Lambeth CCC. Mr Rigg had already left the hostel by this time, but Ms Wood was not aware of this. She still believed that Mr Rigg was posing a threat to her staff and the other residents within the hostel.

296. Ms Wood informed Mr Coleman that Mr Rigg was a risk to public safety, and he was now throwing karate punches at her staff. She described him as extremely violent and extremely dangerous.

297. Mr Coleman annotated the CAD to the effect that Mr Rigg was now using martial arts on the staff at the hostel and they were unable to leave the building. At 7.40pm, this CAD was linked to 6148.

CAD7776 (7.29PM)

298. At 7.29pm, PS David Smith at Lambeth CCC received an emergency call from a member of the public, Witness A. Witness A states in her call that a man (Mr Rigg) had just tried to karate kick an innocent passer-by. She said that this happened in the area of Atkins Road. The man missed with his karate kick, but he briefly

gave chase to the passer-by until he began to run to get away from him.

299. Witness A described the man as bare chested and wearing white trousers.

300. This call was recorded by PS Smith on the CAD and allocated an ‘I’ grade for an immediate response.

CAD7789 (7.30PM)

301. Almost simultaneously another member of the public dialled 999 to report on Mr Rigg. Mr Liam Jung got through to the Bow CCC at 7.30pm and his call was taken by Ms Belinda Crane.

302. Mr Jung described Mr Rigg’s actions in the same way as Witness A. He also added that Mr Rigg had threatened at least two lots of people and a third person had taken refuge in his car and had managed to drive away, although not before Mr Rigg attempted to gain entry to the vehicle by trying to open the door.

303. This call ends when Mr Jung says that he can hear police sirens approaching and says that he will point the police in the direction of Mr Rigg when they arrive.

304. When the actions of Mr Rigg are described to Ms Crane, she identifies that, *“…he must have mental health issues”* and records this on the CAD at 7.34pm.

305. At 7.31pm, this CAD is linked to CAD 7776, the call made and recorded one minute earlier by Witness A. As this CAD is linked, it is appropriately graded as an ‘R’.

306. At 7.32pm, a call was put out on the radio for a unit to attend, and at 7.35pm, the CAD was sent to LD2N via the MDT. LD2N responded and at 7.37pm the CAD shows that the police are on the scene with

the caller.

CAD8062 (7.52PM)

307. At 7.52pm, the final call was made in relation to Mr Rigg. The call was placed by Ms Wood and the call handler on this occasion was Mr Maurice Gluck based at the Hendon CCC.

Ms Wood was aware that Mr Rigg was no longer at the hostel but she was obviously unaware that by now Mr Rigg has been arrested. She was still insistent that police assistance was required as he was, *"…out on the street, and is a threat to the public…".*

308. Ms Wood is told by Mr Gluck that a unit will be deployed as soon as one is available, although Ms Wood is not satisfied by this response. She says that she has been already waiting for three hours and then attempts to emphasise the seriousness of the situation by again describing Mr Rigg's behaviour in the previous few hours.

309. A discussion ensued between Mr Gluck and Ms Wood around mental health and the police response or the perceived lack of it. The discussion ends with Mr Gluck terminating the call as he felt that, at that point they were "going round in circles".

310. Mr Gluck updated the CAD, and linked this CAD to the original working CAD at 7.53pm.

311. At 8.00pm, unit L3N was deployed to attend the hostel in Fairmount Road.

Post mortem

Dr Nicholas Hunt

312. The post mortem examination of Mr Rigg was carried out by Dr

Nicholas Hunt, a Home Office Pathologist. The post mortem took place at Greenwich Public Mortuary on the afternoon of 22 August 2008.

313. Dr Hunt's conclusions are as follows;

- *Sean RIGS* [sic] *was an apparently adequately nourished, adult man who has suffered a cardiac arrest and died whilst in Police custody. This appears to have followed a disturbance involving Mr RIGG which the Police were called to attend and a subsequent chase. I note the history of paranoid schizophrenia and treatment with Haloperidol, the last dose being received in June 2008. These factors may indeed be relevant to this man's cardiac arrest and death.*
- *Much of the evidence of fact in this case regarding the wider circumstances of his death is beyond my competence to determine and therefore if my understanding of the event should prove to be incorrect it is important that I am made aware of this, in order that I am able to reconsider and if necessary revise any of my opinions.*
- *I have considered the possibility that this man's death relates to the direct effects of positional asphyxia during restraint and can find no evidence that this is the case.*
- *There is no toxicological evidence to indicate that he was intoxicated with any illegal substance such as heroin or cocaine at the time of his death and the features of the case do not amount to those of an excited delirium in relation to cocaine toxicity. I note that although the results of toxicology on samples provided to Police/IPCC have been requested I am still not in receipt of these. In order to prevent any further delay I have issued this report on the assumption that when these do become available there will be no significant difference between these and the findings of Dr PATERSON upon which I am basing my opinion at this stage. If this does not prove to be the case then I reserve the right to reconsider these opinions.*

- *Detailed examination of his heart has been undertaken by Professor Mary SHEPHERD, a respected authority in cardiac pathology in the United Kingdom and she could find no evidence of any obvious structural abnormality on naked eye inspection of the heart, nor could she find any abnormality on examination of sections of the heart under the microscope.*
- *Dr Safa AL-SARRAJ has examined the brain in great detail. Dr AL-SARRAJ is a respected authority on neuropathology and he could find no evidence of trauma or any abnormality that would account for death. The observed changes in the brain are those one would expect following a cardiac arrest and a prolonged attempt at resuscitation.*
- *The sections of other organs examined by myself do not reveal any occult natural disease that could account for death.*
- *There are multiple areas of blunt impact type injury principally in the form of grazes (abrasions) and bruises. All of these are in themselves trivial and would not have contributed in any direct sense to his death at this time.*
- *There are injuries entirely consistent with the placing of handcuffs on his body and movement against these cuffs.*
- *There are bruises on his right hand that would be consistent with the account given of him landing punches on another person.*
- *There is no evidence of forceful blows being delivered to his face such as one may see following punches, kicks or stamping.*
- *There are no features of baton strikes.*
- *With respect to the causation of the other injuries it is important to consider the circumstances of the case and the evidence of fact in regard to this should be tested by the appropriate parties.*
- *In essence, the medical cause of death in this case is unascertained. It is however possible to speculate that the circumstances in which he suffered a cardiac arrest are likely to have proven physiologically stressful to him including release of adrenalin. Such situations may be predicted to influence any*

underlying propensity to develop an abnormality of heart rhythm and subsequent cardiac arrest, be that due to his paranoid schizophrenia and its treatment or to an underlying and undetectable 'channelopathy' of the heart.

- *The rib fractures are typical of resuscitation and I attribute no further significance to them.*
- *In my opinion, the cause of this man's death remains:*
  - *1a. Unascertained*

Professor Peter Vanezis

314. The family of Mr Rigg commissioned their own pathologist to conduct a second post mortem and to submit a subsequent report. This second post mortem was carried out by Professor Peter Vanezis at Greenwich Mortuary, and took approximately one hour to complete.

315. Professor Vanezis' conclusions are as follows;

1. *Sean Rigg was a man of 40 years who had a long standing history of paranoid schizophrenia. His mental problems first came to the attention of the psychiatric services when he was 20 years old.*
2. *He was known to have sickle cell trait but this had not manifested itself clinically and had therefore not affected his well being in any way.*
3. *He died in police custody and despite all investigations carried out, the cause of his death remains unclear.*
4. *From the post-mortem examination, there are a number of injuries on his body which are not unusual in the circumstances in which he was detained. These are as follows:*
   - *The bruising and graze marks around the elbows with impact against surfaces during the course of a struggle whilst being restrained. It is possible that a small number of the marks could be due to gripping in those areas, or possibly striking the area*

with a hand. These injuries are consistent with the account given, "he jumped over one or two fences and then [was] *grabbed by a police officer. He managed to get one arm free with which he hit the officer. Sean was then taken to the ground and restrained."*

- *The marks around the wrists and forearms are typical of handcuff marks. Marks from handcuffs are typically accentuated by pulling the wrists against the cuffs, usually while the handcuffed person is continuing to resist during restraint.*
- *The injuries to the right side of his face are impacts against a surface at least twice. These injuries could have occurred whilst he was in the police van or before he was placed in the van. They are not consistent with pressure points being applied.*
- *There were injuries to the back of both hands, more extensive on the right. Such marks could have been caused by Sean striking out at the officers although I cannot rule out the possibility that they may have been defensive injuries occurring during attempts to restrain him.*
- *The marks on the back are consistent with impacts against surfaces, either inside or outside the police van.*
- *The graze marks to the left arm could have been possibly whilst jumping over the fence although there are other possibilities depending on the various surfaces encountered during the incident.*
- *The graze marks to the legs are in keeping with falling to the ground.*
- *The injuries found clearly do not indicate that there had been substantial trauma to the body by a third party. Indeed, trauma did not play any part in his death.*

5. *The pathological findings did not show any evidence that there had been asphyxia. Such findings principally would have included petechial haemorrhages in the eyes and elsewhere, florid hypostasis,*

marks around his neck, injuries to the inside of his lips and gross congestion of the organs.

6. *He was not under the influence of any drugs or alcohol at the time of his death.*
7. *It is very likely that he had not had his last injection of haloperidol although the toxicologist could not be certain of this.*
8. *The early ischaemia found in the brain is not specific and is very commonly found in persons dying both from natural and unnatural causes. There was no evidence of trauma to the brain.*
9. *The findings in the heart do not rule out the realistic possibility that he could have died as a result of a cardiac arrhythmia as stated by Dr Sheppard especially during a state of high excitement when there is an increased catecholamine rush increased motor activity with the requirement for much oxygen, which may not be forthcoming during restraint.*
10. *As stated above, the cause of Sean's death is unclear as is the position with many deaths in such circumstances. All one can say is that his death was related to restraint and the most likely scenario being that described in conclusion paragraph 9 above.*

Forensic medical analysis

Mr Andrew McKinnon

316. Mr Andrew McKinnon is an expert in forensic toxicology who works for the Forensic Science Service in Lambeth.

317. Mr McKinnon was asked to examine and test Mr Rigg's post-mortem samples to determine to what extent, if any, he may have been intoxicated through alcohol, or under the influence of illicit or medicinal drugs, at the time of his death.

318. Mr McKinnon was provided with Mr Rigg's post-mortem blood, urine

and vitreous humour samples for him to test for alcohol. Mr Rigg's blood and urine samples were tested for the following drugs of abuse cannabis/cannabis resin, amphetamine, ketamine, heroin/morphine, MDMA ("Ecstasy"), cocaine and methadone. Tests were also undertaken on the blood and urine samples for a wide range of common medicinal drugs. Mr Rigg's blood was also tested for haloperidol.

319. The examination of Mr Rigg's blood sample confirmed the presence of Haloperidol and atropine (which was administered in the resuscitation attempt), but detected no alcohol.

320. The examination of Mr Rigg's urine could not confirm the presence of drugs of abuse or otherwise. No alcohol was detected.

321. The examination of Mr Rigg's Vitreous Humour showed there to be no alcohol in this sample.

322. In conclusion Mr McKinnon states,

1. At the time of his death Sean Rigg would not have been under the influence of alcohol.

2. When he died he would not have been under the influence of cannabis/cannabis resin, amphetamine, ketamine, heroin/morphine, MDMA ("Ecstasy"), cocaine or methadone.

3. Mr Rigg had taken or been administered haloperidol at some stage. However the indicated concentration in his post-mortem blood specimen is low and below the usual therapeutic range. This could indicate that it was having a reduced therapeutic effect around the time of the incident.

4. The results indicate that Mr Rigg had taken or been administered the sleep inducing medication zopiclone. However the results are consistent with nonrecent usage and he would not have

been under the influence of this drug at the time of his death.

5. On the basis of the other negative results, there is no analytical evidence to suggest that Mr Rigg was under the influence of certain other illicit or medicinal drugs when he died.

Dr Safa Al-Sarraj

323. Dr Al-Sarraj is the head clinical neuropathology at Kings College Hospital in London.

324. Dr Al-Sarraj performed the macroscopy and microscopy examination of Mr Rigg's brain. In his opinion the,

"Examination of the brain shows evidence of early ischaemia (A low oxygen state usually due to obstruction of the arterial blood supply or inadequate blood flow leading to lack of oxygen in the tissue) *demonstrated by deposition of βAPP in the white matter consistent with history of cardiac arrest and resuscitation.*

The congestion of blood vessels is also in keeping with this diagnosis. There is no evidence of traumatic injury to the brain".

325. Dr Al-Sarraj concluded that his examination shows there to be, *"Early ischaemia"*

Dr Susan Paterson

326. Dr Susan Paterson, the head of toxicology at Imperial College London, prepared a toxicology report on Mr Rigg on 10 September 2008.

327. In her report she simply states that there were no Morphine or Amphetamines found in Mr Rigg's blood. Dr Paterson finishes her report by saying, *"No drugs detected in general screen of blood".*

Dr Mary Sheppard

328. Dr Mary Sheppard is a consultant in histopathology at the Royal Brompton Hospital in London.

329. Dr Sheppard examined Mr Rigg's heart both macroscopically and microscopically.

330. With regard to the macroscopic examination, Dr Sheppard's conclusion is, *"Normal heart macroscopically".*

331. Following the microscopic examination, Dr Sheppard summarised her findings as follows,

Sudden cardiac death with morphologically normal heart.

In view of the lack of other causes of death, electrical abnormalities such as the channelopathies (neuromuscular conditions) *must be considered in this case.*

There is a link between psychosis and sudden cardiac death has been established since the 1980s accounted for part of this excess mortality but deaths from natural causes and accidents were also elevated. Comorbid substance misuse doubled the risk of sudden death in affective and schizophrenic disorders. Psychosis with delirium may lead to cardiac death resulting from oxygen-consuming motor hyperactivity, excessive catecholamine (neurotransmitters and hormones) *release, and impaired breathing.*

There is an association with Schizophrenia and psychotrophic drugs in sudden adult death. Psychotropic drugs cause prolonged Q-T on the ECG leading to cardiac arrhythmias and sudden death.

Dr Malcolm VandenBurg

332. Dr VandenBurg is a registered expert witness who is a specialist in general medicine, a consulting pharmaceutical physician and a psychiatric clinical investigator.

333. He was commissioned by this investigation to provide his opinion about the cause of Mr Rigg's death. Dr VandenBurg was specifically asked to exam any causal link between his death and his mental health and medication.

334. In his report, Dr VandenBurg discusses many possible contributing factors to Mr Rigg's death.

335. Some of his more salient conclusions are outlined below.

336. Dr VandenBurg states 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.

Such circumstances include the fact that schizophrenia per se is associated with sudden death, increased mortality, abnormal autonomic nervous activity, and a possible predisposition to arrhythmias.

His symptoms worsened as he did not have his medication as appropriate and his dosage had been decreased. Although this does not rule out the possibility of an arrhythmia consequent on the haloperidol alone (highly unlikely), or in association with stimulation due to restraint (possible, though unlikely) it remains a possibility. In addition we do not see on CCTV restraint excitation, although with hands in the rear stack position psychological and physiological stress is possible, and this could interact with the autonomic dysfunction and haloperidol, although this is at a very low concentration. There is post mortem redistribution of haloperidol,

but I do not think this is material to the case.

The possible drinking of his own urine could have altered his plasma concentrations of salts to increase any possible excitability of the heart.

His taking of Chinese herbal compounds could, if they contained cardiac stimulants as many do, have interacted with restraint and other stresors [sic] *and stimulants.*

The absence of any ECG is disastrous to the assessment of the case and if one was never done this would not be compatible with good practice in the light of his haloperidol.

In my opinion the most likely cause of death in the absence of any other more obvious traumatic cause would be stress due to restraint in association with a predisposition to cardiac arrhythmias consequent on schizophrenia, the low concentration of haloperidol, and any possible excitation from Chinese herbals medication.

This would have been exaggerated by being in the rear stack position in an inappropriate holding area, and possibly due to the fact that he was not left lying down, I cannot exclude the part played by the Police Officers belief that he was pretending.

Professor Jack Crane

337. Professor Crane is a medical practitioner and the State Pathologist for Northern Ireland. He is the Professor of Forensic Medicine at The Queen's University of Belfast and a consultant in Pathology.

338. Prof Crane was asked to provide his opinion about the extent, if any, that restraint played in the death of Mr Rigg. He was also asked to comment on what effects the method of arrest transportation and detention in the cage area may have contributed to death. Finally, Prof Crane was asked to comment on the conclusion of Prof

Vanezis that, "…death is related to restraint".

339. In his report, Prof Crane starts his comment and opinion section by saying that,

*"There is in my opinion, no evidence to indicate that restraint, during arrest or subsequently, played a **direct** part in Mr Rigg's death".*

340. He goes on to explain that,

*"Deaths directly related to restraint occur at the time of the restraint and **not** subsequently when the restraint has been relieved. It could be argued that restraint could play an indirect part in deaths of this type by increasing cardiac stimulation, raising the pulse and blood pressure, causing muscle exhaustion and increasing the body temperature. However the restraint per se would no more increase these "risk" parameters of sudden death than other activities associated with rise in heart rate etc., eg aggressive or violent behaviour, extreme exertion or resisted arrest.*

*The method of arrest, detention in the van and movement to the caged area outside the custody suite did **not** in my opinion play a **direct** part in Mr Rigg's death".*

341. When Prof Crane describes what happened to Mr Rigg, he is critical of some of the individuals involved in his care.

*"Mr Rigg's position in the caged area outside the custody suite would **not** have contributed to his death, however it is apparent that his condition and behaviour changed and his urination, slumping to the ground and twitching are all highly suggestive of his having taken an epileptic-type fit. It is a matter of serious concern that this behaviour was interpreted as "feigning a fit" by one of the officers. Mr Rigg's condition at this time should have prompted an immediate response. A forensic medical examiner was called to see Mr Rigg and appears to have made no attempt to properly assess his*

condition. After the doctor left the caged area it seems that Mr Rigg's condition deteriorated further and that he suffered a cardio-respiratory arrest. Resuscitation was instituted by the police officers and when the forensic medical examiner was re-called to the scene he would appear to have taken no part in supervising or assisting in the resuscitation process. At this stage of events Mr Rigg was dead".

342. Prof Crane also states that,

"It is my opinion that the critical event took place shortly after Mr Rigg was placed in the caged area outside the custody suite. I do not think that the police officers appreciated the sudden deterioration in Mr Rigg's condition and, of particular concern, is the failure of the forensic medical examiner to make a proper assessment of his condition and ensure that he received prompt and appropriate medical attention".

343. When considering the cause of death, Prof Crane points out that,

"It must be appreciated that it is only exceptionally that the pathological findings are so unequivocal as to point to a definitive cause of death. In the majority of cases the pathological findings or the lack of pathological findings must be considered in association with the circumstances surrounding the death. Furthermore it is usually easier to "exclude" causes of death than to incriminate others with a sufficient degree of certainty".

344. However, he does go on to comment on six possible causes of death.

345. **Positional / postural asphyxia:** Prof Crane says that he would,

"…exclude this as being the cause, or indeed a factor, in Mr Rigg's death".

346. **Restraint:** *"…there is no evidence to suggest that restraint during Mr Rigg's arrest or indeed subsequently, played any direct part in his death".*

347. **Injury:** *"There were no injuries to suggest that Mr Rigg had been subjected to a deliberate sustained assault".*

348. **Drugs / Alcohol:** *"Mr Rigg was not under the influence of drugs or alcohol at the time of his death".*

349. **Excited Delirium:** ***"****This condition, which is typically associated with the use of cocaine, is characterised by bizarre and aggressive behaviour, delusions, paranoia and a high body temperature may result in collapse and sudden death and has been frequently reported as occurring during or following restraint. A similar excited state may occur as a form of acute psychosis in schizophrenic patients…"*

"It is clear that Mr Rigg had not taken cocaine and it is my opinion that his behaviour was a feature of an acute psychotic episode in an individual suffering from schizophrenia and possibly linked to non-compliance with his antipsychotic treatment. It is well recognised that there is a significantly increased risk of sudden collapse and death (2 to 3 times above normal) in patients suffering from schizophrenia and that such events may be triggered by an acute psychotic episode such as in this case. The mechanism of death is unclear but may be related to increased cardiac stimulation leading to a cardiac arrhythmia".

350. **Sickle Cell Trait:** *"It is my opinion that there is no evidence to suggest that Sickle Cell Trait played any part in Mr Rigg's death".*

351. Prof Crane ends his report with his conclusions. These are as follows,

"Individuals with schizophrenia have a significantly increased risk (3

fold) of sudden death compared with the general population. This risk is probably further increased by an acute psychotic episode which may or may not be complicated by Excited Delirium. In this case I believe that Mr Rigg's death was probably related to his underlying schizophrenia, precipitated by an acute psychotic episode and associated with non-compliance with antipsychotic therapy. I do not believe that restraint during arrest or subsequently played any direct part in his death".

Family questions

352. Since Mr Rigg's death, his family have expressed numerous concerns. They have conveyed their misgivings about the conduct of those who interacted with Mr Rigg on 21 August and before. They have also stated their suspicions about the actions of some Metropolitan police officers, and the subsequent independent investigation carried out by the IPCC.

353. This report will now attempt to explore these concerns as far as is proportionately possible.

354. Mr Rigg's family outlined many of their thoughts and feelings in the complaint dated 12 October 2008. Further concerns were then raised during meetings with the IPCC on 22 September 2008, 14 January 2009 and 31 March 2009. There have also been letters to the IPCC dated 12 October 2008 and 18 May 2009. E-mail correspondence from the solicitors representing the family have also contained questions and queries that the family felt required answers.

355. This investigation has engaged with Mr Rigg's family on a regular basis with weekly updates being provided from January 2009. Through these updates and the disclosure of as much information as the harm test would allow, it is hoped that many of the family's

concerns have already been addressed.

356. The following pages of this report will address many of the issues raised by the family. The headings have been paraphrased and some sections will incorporate more than one concern.

<u>The police failed to respond appropriately to the 999 calls made by the hostel staff.</u>

357. The staff from the Fairmount Road hostel dialled 999 asking for assistance on five separate occasions. These calls were made at 4.53pm, 5.32pm, 6.46pm, 7.19pm and 7.52pm.

358. The call made at 7.52pm was made by Ms Wood. This has been the subject of a separate complaint, the details of which are covered in the attached report at Appendix A.

359. To summarise, the complaint of alleged incivility of the call handler was substantiated by this investigation, however, the allegation that the manner in which this call was handled contributed to the death of Mr Rigg was not. The call was made at 7.52pm, by which time Mr Rigg had already been arrested and was either at the police station or en route with his arrival imminent. Therefore it can be seen that this particular call had no bearing on how the officers dealt with Mr Rigg on 21 August.

360. The specifics of how each call was handled have been outlined earlier in the report. What needs to be examined now is, were these actions appropriate in the circumstances.

361. Within the MPS there are several manuals, guidances and standard operating procedures that inform police officers and staff on how to deal with calls for assistance from members of the public in relation to individuals with mental health issues.

362. At the time of Mr Rigg's death, the MPS had a policy entitled

"Policing Mental Health". This policy and its supporting standard operating procedures provided police officers with guidance on how to deal with incidents involving people with mental illness.

363. Within the standard operating procedures situations are described in which officers may be called upon to provide a policing service to a person with mental health needs in private premises. One of these situations is described as "spontaneous" and is defined as follows;

There are occasions where police are called by the occupier or another member of the public to assist with a person exhibiting a mental illness on private premises….An officer called to or present at such a situation will need to make a judgment as to what action, if any, is required of police, and what is actually permitted within the constraints of the law.

364. The policy also states the powers that are available to officers in these circumstances.

- *Section 17 of PACE provides a power of entry for the purpose of saving life or limb or preventing serious damage to property.*
- *Police have a power and duty under common law to prevent a breach of the peace.*
- *PACE provides a power of arrest for criminal offences.*
- *Section 3 Criminal Law 1967 provides a power to use force to prevent crime.*
- *Common Law provides, under the principle of necessity, a limited power to take the minimum action necessary to prevent a person of unsound mind from causing immediate serious harm to himself or another, of suffering such harm.*

365. This guidance illustrates that the police have the power to deal with potential offenders with mental health issues in the same way as any other potential offender. Mental health warrants and the issue of private or public places need not always be a barrier to the police

carrying out their duties.

366. When the issue of an individual's mental health has been brought to the attention of the police, the above outlines an officer's powers to deal with the said individual. Of course this is only relevant once the officers have been deployed.

367. The guidance on when or if officers are deployed comes from different documentation and, in general, can be a subjective issue open to interpretation.

368. Insofar as the training material goes there are a number of sources which suggest that any reference to an individual with mental health issues should raise alarm bells amongst staff dealing with callers reporting the same. Call handlers and dispatchers should be vigilant for hidden dangers, especially for any incident where there is a suggestion that the caller or other member of the public is in any way vulnerable.

369. The Trainers' Manual suggests that when taking calls from "friends or family members"

…the response will depend upon the scenario and will usually be dependent on something else happening besides the person being mentally unwell.

It goes on to say,

If there is nothing else occurring and the caller simply wants to report that the person has a mental illness then it is appropriate that the caller is referred to his/her GP in the first instance.

370. The above guidance appears a little vague and imprecise, and gives individuals the opportunity to interpret in a variety of ways.

371. The Student Workbook is more emphatic in its guidance on what to

do in such circumstances. It says,

... if police receive a call from a person stating that they require police attendance in relation to a person suffering from mental illness, i.e. they are displaying odd/violent behaviour whether in a PUBLIC or PRIVATE place, police MUST attend.

It adds that,

The TSG are trained to deal with violent people, whether suffering from mental health issues or not, officers will attend a location and make a dynamic risk assessment. If required, the officers will request the attendance of the TSG.

372. The MPS standard operating procedure says where life is at risk or endangered the call should be graded 'I', be passed to the Borough and the London Ambulance Service (LAS) called. Where no such risks are evident and there is a mental health issue then the call should be graded ‘S’ or ‘E’, and passed to the Borough to deploy.

373. It appears that Ms Goulbourne, who took the initial call at 4.53pm, adhered to the guidance as set out in the Student Handbook.

374. Ms Goulbourne was informed by Mr Alvares that Mr Rigg had a history of mental illness, she asked what his condition was, details of the incident that had occurred and the current status of Mr Rigg. Mr Rigg’s behaviour could readily be described as “odd” as mentioned in the Student’s Workbook, and therefore according to the Workbook, the police must attend.

375. The situation as described by Mr Alvares did not warrant the immediate attendance of police as per the definition of an ‘I’ call. However, the combination of mental health issues and odd behaviour requires police attendance, and therefore an ’S’ grade was appropriate.

376. Ms Goulbourne was correct in her assessment of the call and designated the appropriate grade of 'S'.

377. Having said this, Ms Goulbourne could have informed Mr Alvares fully about what would then happen. Ms Goulbourne, by designating an 'S' grade, had identified that there was a requirement for the police to attend the hostel. With an 'S' grade the intention is that the police would attend within 60 minutes.

378. However, the seriousness with which the police were treating this call was not conveyed to the caller. It is easy to understand how the caller may have felt that a situation he deemed to be extremely serious, was not being treated as such.

379. When Mr Alvares initially explained why he was calling, Ms Goulbourne says, *"The police aren't going to come out for that".* Towards the end of the conversation she says,

"I've typed out and I've said exactly what I've typed out, I want to be upfront with people I don't want you to think policeman that there will be whizzing round there probably not but I'm sure someone will give you a call but I've sent it down you've got a reference number 6148".

380. The tone of the conversation from Ms Goulbourne appears to convey that there may be little the police can do in this situation, which caused obvious frustration for Mr Alvares and Mr Stevens.

381. Whereas in actual fact the call was handled appropriately. The actions of Ms Goulbourne, if not her words, showed that she understood attendance was necessary, and she put the wheels in motion for this to happen. The CAD raised by Ms Goulbourne then became the "working CAD" to which all subsequent related calls were linked.

382. The second call made by Mr Stevens at 5.32pm, was brief, lasting

only one minute.

383. Mr Stevens informed the operator that Mr Rigg had damaged garden furniture, and was now lying down in the garden. This information was added to the CAD, and linked to the earlier call. The new information did not warrant a change of the grade designated to the incident, and therefore this second call was handled correctly.

384. The next call was at 6.46pm, made by Mr Stevens and lasted two minutes and 40 seconds. Mr Stevens was asking for an update on the police attendance as it was now nearly two hours since the initial call. The only new information given was that Mr Rigg was now in his room.

385. The operator asked if a mental health professional had been called, to which Mr Stevens replied that a duty social worker had been notified. The operator then informed Mr Stevens that the request was on their list and as soon as someone was available, they would attend the hostel.

386. Ms Wood dialled 999 at 7.19pm, and her call lasted three minutes and 40 seconds. The operator noted the extra information that Mr Rigg had been throwing karate punches at the staff at the hostel. The operator sent this new information down to the station.

387. In conclusion it can be said that the above four calls were handled appropriately by the call handlers, notwithstanding the suggestion about imparting more information to the caller.

<u>Why didn't the police attend within the one hour target time.</u>

388. There were six attempts made to dispatch officers to the Fairmount hostel between 5.39pm to 6.05pm, but no officer attended. These attempts were made via the MDT as detailed earlier in the report.

389. As outlined previously, the 999 call made at 4.53pm was designated an ‘S’ grade by the call handler. This phone call finished at approximately 5.00pm with the next ten minutes being taken up by the call handler’s supervisor, Mr Price, downgrading and then re-grading the call back to its original ‘S’ grade.

390. In his statement dated 8 September 2009, Mr Price says that after downgrading the call to ‘R’ he phoned Mr Alvares. Mr Price says,

“I had a conversation with Jason Alvares to discuss the context of the call and determine what sort of police response was appropriate. The original text suggested he was under the care of a mental health team, Jason being one of the support workers. As a result of that conversation it became evident Mr Rigg was no longer inside the premises but in the front garden. I asked him if the garden was in full view of the public and Jason told me that it was”.

He goes on to say,

“I determined there was a risk to the public but not so immediate as to warrant the call being graded as an ‘I’”.

391. This course of action by Mr Price was a perfectly legitimate one for him to undertake in his role of call handler supervisor.

392. Following this decision, at 5.10pm Mr Price moved this call from the “awaiting supervision list” to the “awaiting deployment list”.

393. Also in his statement, Mr Price explains that as this call related to a recent incident it would have gone to the bottom of the awaiting deployment list and then moved up the list as other calls came in.

394. At 5.32pm, the second call came in about Mr Rigg. Mr Price says that this call was,

“ …saying criminal damage was being caused by Mr Rigg to a

gazebo in the garden. The text of that call suggests that although he had caused damage he was calm. Therefore, there did not appear to be grounds to upgrade the call to an 'I'".

Mr Price then closed this call and linked it to the original call relating to Mr Rigg.

395. At 5.39pm, Mr Price attempted to despatch a unit to Fairmount Road in response to the previous two 999 calls. According to Mr Price's "Resource Display Window", the police unit with the callsign LD22D was available for deployment.

396. LD22D was a police vehicle that had been allocated PC David Howard as its driver and PC John Collins as the operator. In their statements they recall that they had been dealing with a domestic violence incident that afternoon. At the times the attempts were made to despatch them to Fairmount Road the officers and vehicle were at Brixton Police Station.

397. PC Collins says that the details of the domestic violence incident were entered by him onto the Crime Reporting Integrated System (CRIS) computer at 5.19pm. Neither officer has any recollection of their movements following the conclusion of these events. This is not surprising considering that the officers were not asked to provide statements about the events of 21 August until 11 months after the incident.

398. Although the last evidence of these officers' activity can be timed at 5.19pm, it is not unreasonable to assume that they may not have immediately returned to their unit. The fact that they did not respond to the attempted despatch via MDT at 5.39pm also seems to suggest that they remained in the police station for a period of time.

399. At 5.45pm, Mr Price again attempted to despatch a unit to the incident. This time his resource window was showing unit LD23D to

be available. This was the first of four attempts to despatch this unit. Mr Price tried again at 5.51pm, and then Mr Turner attempted at 5.56pm and again at 6.05pm.

400. PC Paul Lightfoot was allocated to this unit as the driver with PC Jordan Jansen as the operator. At the time of these attempted dispatches, unit LD23D was parked in the yard at Brixton police station.

401. PC Lightfoot states that at 2.52pm he and PC Jansen were called to a public order incident that resulted in the arrest of a drunk female. At the police station PC Lightfoot entered the details of this incident onto the CRIS computer whilst PC Jansen booked her in to the custody suite. PC Lightfoot states that he completed the CRIS entry at 5.24pm, whilst PC Jansen states that his last entry relating to this incident was date stamped by the computer at 6.24pm.

402. It is clear to see that these officers and this unit were not in a position to be able to respond to the CCC's attempts to dispatch them to Fairmount Road.

403. The situation regarding the third vehicle that the CCC attempted to dispatch is clearer cut. At 6.01pm, the CCC sent the CAD to the MDT of vehicle LD2D. At this time it can be seen from computer records that LD2D was en route to another incident in response to CAD 10079 and therefore clearly not in a position to attend the hostel.

404. Two issues appear to be highlighted by the above set of circumstances. Firstly, why were the units shown as being available to attend serious incidents when it is obvious that they were not, and secondly, why did the dispatchers give up on their attempts to find a unit to deploy.

405. It is the individual officer's responsibility to operate the MDT

appropriately and not the CCC's. If the officers in LD22D, LD23D and LD2D were working the system correctly, then they would have been shown as unavailable to the CCC, and the dispatchers may have pursued other options with regard to deployment.

406. Having said this, the system does have the "failsafe" of the automatic "no answer" response, therefore no more than two or three minutes are lost in the situation where an officer does not indicate they are unavailable.

407. With regard to the second point, this investigation has not been able to resolve this question with any degree of certainty. The first possible explanation could be that the final attempt to deploy a unit was made at 6.05pm, with the "no answer" response coming in at 6.08pm. This was 58 minutes after the supervisor put the call on the awaiting deployment list and 72 minutes since the initial 999 call was made.

408. By this time the target for deployment to an 'S' call had been missed and therefore statistically there would be more benefit in responding to other 'S' calls still within the 60 minute target window.

409. The second explanation could be that this particular call was simply "overtaken" by calls that were deemed to be more serious or imperative in their nature.

410. The above possibilities are speculation as there is no way of knowing for certain why the attempts to deploy stopped.

411. Although the police response to these 999 calls would not be described as ideal it needs to be noted that it was not unique.

412. This call was quite rightly designated as an 'S' call and therefore by definition was not treated as top priority. The Metropolitan Police Service's target for attending 'S' calls within 60 minutes is 75% and therefore there is an acceptance that 25% of these calls will not be

dealt with within the hour.

413. In the year from April 2008 to March 2009, the MPS as a whole achieved the 60 minute target response time only 51.8% of the time. This meant that the police responded to 166,185 ‘S’ calls within 60 minutes out of a total of 320,924.

414. Lambeth BCU is one of 33 geographical command units within the MPS. Lambeth achieved the target for ‘S’ calls 50.5% of the time. Numerically this equated to 14,744 calls being designated as ‘S’ calls, with 7,446 of these being responded to within the 60 minute target time.

415. To make these statistics more relevant to Mr Rigg’s death, they have been broken down further to ascertain the performance of Lambeth BCU for the month of August 2008.

416. For the month of August, Lambeth had 1,328 calls designated as ‘S’ grades with 674 of those being attended to within 60 minutes. This is 50.8%, fractionally above the MPS achievement for August of 50.0%.

417. The final statistic that informs our understanding of the police response that day is the average time of the response to ‘S’ calls. For Lambeth BCU, their average response time was 3 hours 30 minutes and 46 seconds. This is 13 seconds slower than the MPS wide average of 3hrs 30mins 33 secs.

418. The above statistics show that the response to ‘S’ calls in the MPS as a whole falls well below their own target. The results for Lambeth BCU are very similar to the MPS average. In actual fact, only 11 of the other 32 MPS BCUs performed better than Lambeth in the year April 08 to March 09.

419. The reasons for the poor performance of the MPS and Lambeth will inevitably be varied and complicated, but do not form part of the

terms of reference for this investigation. These statistics however do shed some light on the bigger picture regarding the ability of the MPS to respond to non-emergency calls.

420. 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. Unfortunately, in many circumstances it is just not possible for the police performance to match up to the often unrealistic public expectation of them.

<u>Officers did not recognise Mr Rigg as a person with mental health needs.</u>

421. The above statement, according to the officers is true. Therefore the question needs to be asked, should they have recognised him as a person with mental health needs?

422. All of the officers state that they had no prior knowledge of Mr Rigg or the hostel at Fairmount Road.

423. They were responding to an emergency call that was made at 7.29pm. It was allocated to the officers two minutes later, and seven minutes after that Mr Rigg had been arrested.

424. The member of the public that called in at 7.29pm had no idea there were any mental health issues and did not know who Mr Rigg was. There was no mention of mental health issues on the CAD that was passed to the officers via the MDT.

425. Even if the officers had been aware of Mr Rigg's medical history, the arrest and restraint would not have been handled any differently. Mr Rigg was a man acting in an aggressive and violent manner that attempted to evade arrest. He had assaulted a police officer and was restrained accordingly.

426. The situation following his arrest could have been handled differently if the officers had realised that Mr Rigg was suffering from a mental illness.

427. It is of some concern that following Mr Rigg's arrest, none of the four officers involved considered the possibility that there may be an underlying cause for his behaviour.

428. 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.

429. 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.

430. Despite all the above indicators, none of the officers considered the possibility that Mr Rigg may have been suffering from a mental illness.

431. If this possibility had been identified, 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…

432. 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.

Officers did recognise that Mr Rigg had mental health needs, but failed to treat him as such.

433. There is no evidence to suggest that the officers did recognise Mr Rigg as a man with mental health needs.

Why were the calls made by the hostel staff not linked to the calls made at 7.29pm and 7.30pm.

434. In order for calls to be linked, there needs to be some commonality. The CAD system can recognise and automatically link calls where certain fields on the computer are completed with the same information as in previous calls. These fields are the geographical location of the incident and the name and contact details of the informant.

435. There was nothing common within the calls that allowed the computer to make any links.

436. Calls can also be linked manually. This requires personal knowledge on the part of the call handler. The call handlers who took the calls at 7.29pm and 7.30pm, were not involved in the earlier calls made by the hostel staff, therefore no link was able to be made manually.

Officers used excessive force that led to him being assaulted.

437. There is no CCTV coverage at the scene of Mr Rigg's arrest, and therefore there is no independent footage that can definitively demonstrate the manner in which Mr Rigg was arrested and restrained. This investigation has to rely upon eye witness testimony and forensic evidence.

438. As mentioned previously in this report, there were 11 independent

witnesses who saw varying amounts of the interaction between the police and Mr Rigg. There is also the testimony of the four officers involved.

439. Nine of the 11 witnesses recall a broadly similar account of what they saw on 21 August. They paint the picture of Mr Rigg struggling and the police officers attempting to restrain or subdue him.

440. Five of these nine witnesses comment in their statements that they did not see the officers use any excessive force or violence towards Mr Rigg.

441. Of the other two witnesses, Ms McDill, in her statement describes a very different set of circumstances. She says that she saw Mr Rigg up a tree, with the officers attempting to pull him down from the tree. She recalls one officer had hold of his leg for about five minutes until they finally succeeded in getting him to the ground. Once on the ground, the officers kept him there for approximately 30 minutes.

442. One of the officers then punched Mr Rigg in the chest. A different officer then punched him in the chest four times with some force.

443. The testimony of Ms McDill is so far out of kilter with the evidence of the other witnesses that it allows this investigation to attribute little, if any credibility to it. This position is also backed up by the fact that the post mortem does not corroborate her account. It showed no injuries to the chest area of Mr Rigg.

444. The other witness who gives a different account is Witness C. She has provided two statements recounting what she saw on 21 August 2008.

445. With regard to Mr Rigg being assaulted by the officers, in her first account she says that as the officers were escorting Mr Rigg to the van, one of the officers hit Mr Rigg with his own shoes on the back of his head. She says there were three or four blows that appeared

to be quite hard.

446. In her second statement she recalls these blows were administered with little force and there were at least 20 of them.

447. Despite the inconsistencies in Witness C's recollections and the lack of corroborative witness testimony, a file was referred by the Commissioner to the Crown Prosecution Service (CPS). The CPS was asked to decide whether they felt there was a realistic prospect of a successful prosecution against any of the officers for assault on Mr Rigg.

448. The CPS decision was outlined in their written advice to the IPCC of 6 February 2009.

449. The conclusion of the CPS reviewing lawyer, Mr Carl Kelvin, is that, *"This case is fundamentally flawed".* Mr Kelvin goes on to say,

"I have reached the conclusion that both the witnesses that had the best view of what occurred are unreliable. In those circumstances I am of the opinion that a tribunal of fact would not be able to resolve the conflict so that they are satisfied so they were sure that the account(s) given by Witness C could be relied on".

450. The accounts of the four officers are consistent with each other, and with the testimony of most of the independent witnesses.

451. The post mortem report compiled by Dr Hunt states,

"There is no evidence of forceful blows being delivered to his face such as one may see following punches, kicks or stamping".

452. Dr Hunt also says that there were marks consistent with the placement of handcuffs, multiple areas of blunt impact type injury, principally in the form of grazes and bruises. Dr Hunt describes all of these marks as trivial.

453. There is no evidence to suggest that the officers who arrested Mr Rigg used excessive force. Conversely however, there is evidence to show that the officers acted reasonably and proportionately during Mr Rigg's arrest and restraint.

<u>Mr Rigg was not restrained in accordance with local and national procedures on restraint of persons with mental illness.</u>

454. The MPS has a policy entitled Policing Mental Health, from which the standard operating procedures for delivering a policing service to the mentally ill community has been produced.

455. The section headed "Restraint and Medical Care" says,

There will be occasions where it may be necessary to restrain an individual with a mental illness. Where a person 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 for them by summoning an ambulance to take the person to an Accident and Emergency Department.

456. Another section of the policy is entitled, "Responding to offences where the suspect is mentally ill" with the relevant sub-section, "People arrested by police for non-mental health matters".

457. The section,

…applies to people arrested by police for an offence, under a warrant or for a breach of bail conditions or similar matters where their condition suggests they require medical treatment in hospital.

It then goes on to outline four ways the detained person could get to hospital.

458. Both of these sections from the MPS policy could have been pertinent to the circumstances on 21 August, however, for them to have been implemented, Mr Rigg would have had to be identified with mental health needs and also that his physical condition requires medical treatment.

459. As mentioned in earlier sections of this report, 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.

460. 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.

461. As none of the arrest and restraint of Mr Rigg was captured on CCTV, it is difficult to comment with any certainty about the appropriateness or otherwise of the force and techniques used. Having said this there is eyewitness testimony, including that of the arresting officers, two photographs taken by a witness on a mobile phone, and the post mortem reports.

462. The investigation has also commissioned the services of an expert in restraint techniques to comment on the training provided by the MPS.

463. Police Inspector (Insp) Nicholas Sutcliffe is the officer responsible for Officer Safety Training (OST) within the MPS' Officer Safety Unit based at New Scotland Yard. He is Secretary elect to the Association of Chief Police Officers' (ACPO) Self Defence, Arrest and Restraint (SDAR) Working Group, which is responsible for national Personal Safety Training, policy and guidance. Insp Sutcliffe is also the Chairman elect to ACPO's SDAR Practitioners' Group which is responsible for the review of the national Personal

Safety Manual.

464. In his statement dated 8 September 2009, Insp Sutcliffe describes the stages involved in securing an individual who is violent and resisting arrest. He says that in this particular incident,

“In essence, the significant OST issues apparent in the witness statements appear to centre upon ‘prone restraint’ and its associated risks, the use of handcuffs, and the recognition of significant ‘impact factors’, including mental health issues - and one’s subsequent duty of care”.

He goes on to say,

“The initial control and restraint of violent individuals is usually a fluid and dynamic process, which often ends up on the floor. The reasons for this are twofold. Firstly, gravity will of course prevail in fast moving incidents where one’s balance is often lost. Secondly, the floor is often the safest place (for all) to achieve control and subsequent restraint of a violent person”.

465. Insp Sutcliffe talks about two phases of an altercation with a subtle distinction between them. Firstly the “control” phase, followed by the “restraint”.

466. Insp Sutcliffe states,

“…the period of control or, perhaps more accurately, the period that leads to the control of a violent individual is usually far less structured and significantly more frenetic and potentially dangerous than that of the restraint period”.

467. Once control has been achieved, Insp Sutcliffe says,

“…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. I believe the easiest way to help

identify this transition is by observing the actions of both the officers and the individual. Once control is achieved their actions tend to become increasingly measured and orchestrated. I believe the evidential photographs (MAG/1) demonstrate this point (i.e. the period of 'control' is depicted by the four officers; the period of 'restraint' is depicted by the three officers)".

468. Speaking generally, Insp Sutcliffe says,

"Officers are taught a number of techniques in order to help control violent individuals, which include the employment of rigid handcuffs and empty hand/knee strikes. Such techniques involve varying degrees of 'pain compliance', 'muscular dysfunction' and 'distraction'. Indeed, each assists the officer to achieve a particular lawful goal (e.g. to apply handcuffs to a violent person), which would not otherwise be possible".

469. Specifically about the arrest on 21 August, he says,

"The officers appear to have employed a technique called 'prone subject relocation' whilst restraining Mr. Rigg. This technique is mentioned in the 'multi-officer tactics' section of the MPS OST Manual".

470. With regard to the control and restraint of an individual with mental health issues, Insp Sutcliffe comments that,

"Known or suspected mental health issues would certainly be 'impact factors'. However, in fast moving incidents such observations are not always possible or practicable".

471. Towards the end of his statement, Insp Sutcliffe states that,

"…an overriding principle officers are taught that they have a duty of care to members of the public, that their actions must be proportionate, lawful and necessary in the circumstances and that

they may be called to account for what they have done".

472. The statement of Insp Sutcliffe provides a comprehensive account of the training, thought processes and techniques used when attempting to secure a violent individual. This investigation has 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.

<u>Officers failed to ensure that Mr Rigg was unharmed prior to being removed from the police van.</u>

473. When Mr Rigg arrived at Brixton police station, he was kept in the police van until the custody suite was able to receive him.

474. In an ideal world, Mr Rigg would have arrived and been taken to the custody sergeant in order to immediately commence the booking in procedure. The custody suite was busy and therefore Mr Rigg was kept in the van for approximately 11 minutes.

475. During this time Mr Rigg was under constant supervision. The arresting officers were with him and two sergeants came to the van to check on Mr Rigg's welfare.[1]

476. The officers say that although Mr Rigg was not speaking he was alert and responsive and therefore felt that medical attention was not required.

477. When Mr Rigg alighted the van, he was not in a collapsed state. The officers state that he was walking, and this testimony is corroborated by the CCTV footage where Mr Rigg can be seen to be moving his legs.

478. His behaviour when leaving the police van appears to be similar to

[1] This was proven not to be the case at the inquest. The account given by Sgt White both to the IPCC and initially at the inquest is now the subject of an IPCC independent investigation

his behaviour upon arrest as described by the arresting officers.

Officers failed to monitor Mr Rigg's medical condition and ensure that he received medical attention when it became apparent that he was ill.

479. Once the officers realised that Mr Rigg was in need of medical attention, they immediately called for the FME to assess him. This happened when they saw that Mr Rigg had urinated, an obvious sign of some form of distress.

480. Once the FME had assessed Mr Rigg, the officers monitored his condition by watching his breathing. When his condition deteriorated, they again called for the FME's assistance.

481. It can be seen from the CCTV footage that the officers were in continual close attendance, and their efforts at CPR can be clearly observed.

482. With regard to the CPR, on her arrival, the senior paramedic, Ms Milton, observed the police officer performing the chest compressions and described them as, *"…effective as the rate and depth of them were adequate".*

483. The evidence relating to Mr Rigg's medical condition prior to being taken to the cage area has already been outlined in this report. This evidence includes the testimony of the four arresting officers as well as that of other officers who saw Mr Rigg sitting in the back of the van.

Mr Rigg was assaulted by one or more officers in the back of the van en route to Brixton Police Station.

484. Once Mr Rigg was in the caged area at the back of the van, the four officers got into the van to travel to Brixton police station. PC Birks and PC Glasson were in the front with PC Forward and PC Harratt in

the rear facing seats in the mid-section of the van.

485. The journey from the Weir Estate to the police station is just over two miles. The police van travelled to the station with blue lights showing in order to make the best possible time. The journey took only a few minutes to complete.

486. There is local authority CCTV footage covering most of the police van's journey to the station. There would have been no realistic opportunity for the officers to have stopped the van to assault Mr Rigg. It also seems unlikely that if the officers were intending to assault Mr Rigg, they would have travelled with blue lights on to make the journey as quick as possible, thus allowing the officers a much shorter window of opportunity to carry out their attack.

487. The cage area in the back of the van was examined by a Scenes of Crime Officer (SOCO) as part of the post incident investigation. There was no physical evidence found to substantiate the claim made by Mr Rigg's family. There were no signs of blood or fibres or other material to suggest that any violent contact had been made between the officers and Mr Rigg.

488. There are also the results of the post mortem examination already mentioned in this report. The post mortem results show no evidence of any kind of assault having been perpetrated against Mr Rigg.

489. There are also the testimonies of the four officers concerned. They all give broadly similar accounts of their recollections of the journey from the arrest scene to the police station. These accounts are supported by the physical evidence mentioned above.

490. There is no evidence to suggest that any form of assault took place in the back of van on the way to the police station.

<u>The family believe that the police officers are suspects in the murder or</u>

manslaughter of Mr Rigg.

491. This is obviously the most serious of the allegations made against the officers by the family of Mr Rigg.

492. This view, according to the original complaint letter, is based on their belief that the officers,

- *Did not use the appropriate restraint techniques correctly; Failed to properly monitor Sean's medical condition;*
- *Failed to comply with national or local guidance in connection with the treatment of detainees who appear to have mental health problems;*
- *Failed to take proper steps to ensure that Sean was unharmed prior to being removed from the police van in a collapsed state; and/or*
- *Failed to ensure that he received proper medical attention as soon as it became apparent that Sean was seriously ill.*

493. Above, there are basically five individual elements that when put together constitute the foundation upon which the Rigg family believe that Mr Rigg was killed.

494. Each of these separate aspects has been examined above with our conclusions documented.

495. Following the Crown Prosecution Service's decision not to take any action against the officers, and a review of the existing evidence, it was decided on 25 February, that this investigation would no longer be a criminal investigation. It was still to be a thorough and comprehensive search for the truth, but the evidence gathered thus far did not support the family's assertion that a criminal offence had been committed.

496. Mr Rigg's family were informed of this decision at the time.

497. Of course this decision would be subject to review, and if future

evidence came to light suggesting that criminality may have played a part, then the status of the investigation would revert.

498. Throughout the course of the rest of the investigation nothing was uncovered to suggest that a criminal act had been committed.

499. This investigation has uncovered no evidence to substantiate the family's allegation that the officers should be suspects in the manslaughter or murder of Mr Rigg.

<u>The police and IPCC failed to seal off the scene of Mr Rigg's arrest.</u>

500. Immediately following Mr Rigg's departure to hospital, Insp Morag Palmer was in command in the custody area. She informed Superintendent (Supt) Dave Musker of the situation and arranged for the MPS Department of Professional Standards (DPS) to be contacted.

501. Once Mr Rigg had left the police station with the paramedics, Insp Palmer designated that the area of the cage be cordoned off and secured as a scene. She also decided that the van in which Mr Rigg was transported should be secured as a scene with the keys being locked away.

502. Specifically about the scene of Mr Rigg's arrest Insp Palmer states,

"I did not designate the arrest area as a scene at that particular time I did not know the area particularly well and I do not remember any other conversation with [sic] *relation to this area at this moment".*

503. Detective Inspector (DI) Simon Messinger was the on-call senior officer for the MPS Department of Professional Standards. At 8.54pm he received a call asking him to contact Insp Palmer at Brixton Police Station regarding the arrest of Mr Rigg and his subsequent transfer to hospital. DI Messinger was given a brief

outline of the circumstances as they were known at the time.

504. DI Messinger arrived at Brixton at approximately 10.40pm, three hours after Mr Rigg's arrest. He immediately attended the office of Supt Musker. Supt Musker was present in his office along with Chief Inspector (Ch Insp) Suzanne Wallace, Insp Palmer, PS Dunn and Detective Sergeant (DS) Kathryn Chisholm from the DPS.

505. At this meeting the incident and subsequent investigation was handed over to DI Messinger. At this point the scenes came under his control.

506. With regard to the arrest scene DI Messinger states that,

"During this meeting I asked for a description of the arrest site, whether it was busy, frequented by members of the public and whether any scene would have been contaminated. I have never worked in Lambeth and do not have a working knowledge of the area. I was informed that it was a busy area and members of the public would have walked through. Due to the time that had elapsed between Mr Rigg's arrest and DPS - SI taking over the investigation, my initial thoughts were of contamination and reliability of evidence retrieval".

507. DI Messinger was made aware of the other scenes, namely the custody cage area, the police van, the ambulance and Mr Rigg himself. He said that,

"I was content that these 'scenes' had been controlled from the very outset and that evidential integrity had been maintained. With regard to the area of arrest, the integrity was not guaranteed, as it had never been secured. The answer to my query confirmed in my mind that best evidence could be achieved from those scenes secured, not from an area that had been left open for over an hour, leaving significant scope for contamination".

508. DS Chisholm attended this meeting and recalls that,

"…it became clear that the site of the arrest had not been secured. I recall that DI Messinger asked questions regarding the area in Weir Road. It was clear that he was trying to establish if the area was busy and thus the likelihood of the scene having been contaminated. He was informed that it was a busy residential area. Given the time elapsed from Mr Rigg's arrest at 19:39hrs it was clear that the integrity of the scene could not he guaranteed".

509. This meeting took place in Supt Musker's office and was described by him and Ch Insp Wallace as a Gold Group meeting. They also recall that Detective Chief Inspector Alex Gibbs from the DPS being present.

510. Supt Musker recalls of this meeting that,

"At the initial Gold meeting at 10.30 the scenes at Weir Road, LAS, van and custody were identified".

The area at Weir Road was the scene of the arrest perhaps unbeknownst to Supt Musker as he goes on to state that,

"I refer to my notes here. I believe these scenes were identified by DPS. I also have a note stating that custody had been closed and the van seized by Inspector PALMER. I do not recall any conversations with anyone regarding the arrest scene, as I have no knowledge of the arrest scene. I do not recall any discussions with DI MESSINGER regarding the arrest scene".

511. Ch Insp Wallace says,

"I cannot recall the arrest area being discussed either at the Gold Group meeting or outside the meeting and I did not have any discussions with DI MESSINGER about it".

512. The family of Mr Rigg are particularly concerned about the fact that the site of the arrest was not designated as a scene for the purposes of this investigation. They see this as one of the,

"… specific examples of the ways in which the IPCC have failed to carry out an immediate and rigorous inquiry capable of leading to the identification and punishment of those responsible".

513. With a serious incident of this nature there is always likely to be a great deal of activity initiated prior to the arrival of the senior investigator. The senior investigator on his arrival at the scene should be briefed by the senior officer in command, apprise themselves of the situation and be satisfied that the action being taken is appropriate.

514. Specifically in relation to the scenes of an incident, the senior investigator needs to satisfy themselves that the scene parameters are adequate and that the appropriate measures are taken to effectively protect them.

515. On his arrival at Brixton police station, DI Messinger, as the senior investigating officer, received a briefing from those in command. He reviewed the actions that had been taken prior to his arrival and was then handed control of the incident.

516. Part of DI Messinger's review of the situation included formalising the designated scenes relevant to the incident. He agreed with the steps that had already been taken regarding the securing of the custody cage area, the police van, the ambulance and Mr Rigg himself. DI Messinger also reviewed the status of the scene of the arrest, which by the time of his arrival had not been secured.

517. There is little doubt that the topic of the arrest scene was reviewed and discussed at the initial meeting in Supt Musker's office. DI Messinger and DS Chisholm both recall this discussion in their

statements. Supt Musker recalls that in this meeting the scene at Weir Road (arrest scene) was identified but then goes on to say that there was no conversation about the arrest scene. Ch Insp Wallace holds the most dissenting voice whereby in her statement she says that the arrest scene was not discussed in the meeting or outside the meeting, and she did not speak to DI Messinger about the arrest scene at all.

518. As mentioned before, upon the arrival of the senior investigator, the situation needs to be reviewed and then decisions made. DI Messinger did review the situation and then made a decision about the arrest scene. This decision is documented and rationalised in his policy log.

519. As well as being informed that the site of the arrest would have been contaminated, further rationale for his decision was that he,

"… believed that the key evidence would come from Mr Rigg's body. Any such evidence would then be cross-referenced with those scenes secured. The location of arrest was known and I was satisfied that the officers involved in the arrest had all been identified and were already at Brixton Police Station. No officers directly involved were unaccounted for. I was aware force had been used in the arrest and restraint of Mr Rigg and who the officers concerned were. There was no doubt that there had been contact between the officers and Mr Rigg during arrest and while at Brixton Police Station".

520. Any decision made by a senior investigator can be expected to be subject to scrutiny and review. Some decisions are clear cut and others are subjective and therefore may be a matter for debate. DI Messinger's decision not to secure the arrest scene is one of those decisions.

521. DI Messinger may argue that little or even no forensic evidence at

the arrest scene has been lost through his decision. Having said this, the scene was not secured and therefore this can never be known for sure.

522. DI Messinger made his decision in good faith and should not attract any criticism for it.

523. However, there may be a case to suggest that there would have been more value in securing the arrest scene immediately after Mr Rigg became ill. This again would be subject to the same debate about the evidential opportunities and value of doing this. Having said that, the police have a responsibility to secure and preserve any potential evidence following a critical incident.

524. Although Insp Palmer is neither a senior investigator nor a detective, it does appear that little consideration was given to the evidential opportunities that may have existed at the site of the arrest.

<u>The police interfered with the CCTV cameras at Brixton Police Station.</u>

525. The family of Mr Rigg have great concerns about the CCTV system at Brixton police station. In the original family complaint they state that,

"In the period following Sean being taken to hospital, the police interfered with the CCTV cameras at Brixton police station".

The family provided no information upon which this assertion is based.

526. At the meeting on 22 September 2008, between Mr Rigg's family and the IPCC, they re-iterated their disquiet about the whole CCTV situation. They requested that the terms of reference for the investigation be amended to include the possible tampering of the CCTV. The terms of reference were duly amended.

527. The family of Mr Rigg expanded on their grievance at this meeting. They stated that they knew from their visit to the police station that there was a camera pointed directly at the cage area that, in their opinion, would have captured the activity around Mr Rigg that was obscured from the other cameras. The family also believe that officers placed Mr Rigg in the one position where he could not be recorded because officers were obscuring the camera's view.

528. Another element that has fuelled the family's mistrust about the CCTV is that on their visit to the police station, they recall that Ch Insp Wallace informed them that all the cameras had been working on 21 August. This turned out not to be the case.

529. The whole subject of the CCTV at Brixton police station is an immensely complex one. There are two totally separate CCTV systems in place at Brixton, the Custody CCTV and the Security CCTV. The complicated nature of these systems is such that it required a separate report to explain the two types of system in place, the fault reporting procedures and the relevant dates in the CCTV maintenance leading up to 21 August. This report can be seen in its entirety at Appendix B.

530. Many of the investigations carried out by the IPCC, incorporate certain technical or specialised areas that individuals at the IPCC are not qualified to speak to. The IPCC frequently engages with, and commissions the services of various expert witnesses qualified to testify in these areas.

531. To assist in the appointment of these experts, the IPCC has set up its own Expert Witness Database. This is a centralised list of expert witnesses who have been engaged during IPCC investigations. The database was created to minimise any difficulties experienced in locating expert witnesses qualified in their specialism and willing to assist the IPCC.

532. Mr David Thorne is the owner and Managing Director of Demux Video Services Limited. Mr Thorne's details have been long held as part of the IPCC Expert Witness Database, and his expertise has been used on numerous IPCC investigations. The quality and integrity of Mr Thorne's work has so far never been called into question.

533. Mr Rigg's family have repeatedly raised concerns about the independence of Mr Thorne, mainly because they mistakenly believe that he was an ex-Metropolitan Police Service Officer, as mentioned in their original complaint. Despite being informed on numerous occasions that this is not true, they still assert, in their correspondence of 18 May, that this is the case.

534. Mr Thorne used to be a Bedfordshire police officer. He has never, as a police officer, worked for the Metropolitan Police Service nor had any extended dealings with the Metropolitan Police Service. As far as the IPCC is concerned, Mr Thorne's independence has never been in doubt.

535. Mr Thorne's expertise comprises, among others, de-multiplexing CCTV footage, enhancing video and audio, creating compilation DVDs and confirming the integrity or otherwise of visual recordings.

536. Mr Thorne was asked by this investigation to de-multiplex the police station CCTV footage from the relevant cameras and to make a compilation DVD. He also extracted the audio tracks from the footage and produced DVDs of these.

537. Mr Thorne also produced a compilation DVD including the local authority CCTV footage of Mr Rigg, covering his journey along Brixton Hill from his hostel on Fairmount Road.

538. In accordance with the amended terms of reference for the investigation, Mr Thorne was also instructed to carry out further work

with regard to the integrity of the CCTV footage from Brixton police station. In short, he was asked to examine the videos to discover if they had been tampered with in any way.

539. In Mr Thorne's report he goes into some technical detail about how recording systems work and the examination he undertook (Appendix C).

540. During the course of his examination, Mr Thorne discovered three anomalies in the Brixton CCTV recorded images.

- *"There are additional captures of camera views. The outcome of this is that there are typically additional captures from one of the cameras for a couple of cycles and then this rolls onto a different camera and repeats continuously. Due to this there is typically a gap of between 0.62 and 0.78 seconds between captures from the same camera unless that camera is the one being duplicated in which case the gap is 0.02 or 0.04 seconds. The additional images are correctly time stamped. The camera sequence shown in exhibit DCT/6 has had the additional images removed".*
- *"The camera text is missing. There are some images that do not exhibit the camera text but they are time stamped".*
- *"Some images show incorrect time stamp. These images are typically those that are on the cusp of the time stamp changing to a full second i.e. the previous frame could be HH:MM:09.98 the following capture should be HH:MM:10.00 but is occasionally HH:MM:09.002".*

541. In order to further investigate these anomalies, Mr Thorne then examined the recorded images for the periods before and after the relevant timeframe.

542. In conclusion Mr Thorne states,

"The sequences produced in DCT/22 (the extracts from all videos before, during and after the relevant time) *exhibit the same*

anomalies as those evident in the sequence from DJM/2 (the relevant timeframe extract)*. It is important to remember that the recording process is linear and once an image is recorded to the tape the following image is chronologically later than the previous one.*

All three anomalies are likely to be caused by a fault in the multiplexer equipment affecting the camera input pulse, a fluctuation in the mains voltage or an inconsistency in the system set up which conflicts the number of cameras in the sequence with the number of fields captured per second.

In my opinion there is no evidence to suggest that the images recorded on video exhibit DJM/2 for the relevant period have been altered in anyway".

543. During the family visit to Brixton Police Station on 23 August, Mr Rigg's family recall being told by Ch Insp Wallace that all the CCTV cameras were working. Subsequent investigation has shown this not to be the case.

544. In an attempt to clarify this issue, this investigation asked Ch Insp Wallace to provide an additional witness statement to cover the Rigg family visit.

545. In this statement dated 13 January 2009, she says she was aware that on 22 August, some members of Mr Rigg's family had attempted to *"gain access"* to the station back yard. The family were invited to the front office where they spoke with Duty Inspector Stephen Hughes for approximately one hour.

546. She also describes how that on 23 August, seven family members and one family friend arrived at the Brixton Police Station front counter at approximately 1pm.

547. Ch Insp Wallace invited them to the conference room where they

would be able to discuss the issues. She said she explained her role as "on call" Chief Inspector for Lambeth Borough and that she was in attendance at Brixton police station on 21 August. Ch Insp Wallace explained how the events of that evening unfolded, as far as she understood, and was asked several questions about CCTV.

548. Ch Insp Wallace recalls that the family,

"… enquired about CCTV at the scene of the arrest and in the van. I told them I did not know if there was CCTV where he had been arrested and that CCTV is not fitted in the station van. I showed them around the custody area, including the cage and the back yard. I informed them that the custody CCTV had been in operation at the time of the incident and had been seized as part of the investigation. I knew this to be the case because I had confirmed it had been working with an officer from DPS on the evening of 21st August. I pointed out all the cameras in the yard and identified the areas that they were fixed to view. I also showed them the TV monitors within the custody suite. At the time I was not aware that not all four of the external cameras are connected to the Custody CCTV system".

She goes on to say that,

"I offered to show them the relevant parts of the custody suite, which they accepted. After viewing the custody area the family left…"

549. There is nothing to suggest that the information given to Mr Rigg's family by Ch Insp Wallace was imparted with anything but a genuine intention to inform them of the circumstances surrounding Mr Rigg's death. Ch Insp Wallace did not deliberately mislead Mr Rigg's family.

<u>The police arranged for people in the Weir Road area to be evicted without asking them whether they had witnessed the arrest.</u>

550. There were evictions in the Weir Road area shortly after the arrest of Mr Rigg, but these evictions were not instigated by the police or the local council.

551. The properties in question were in Limerick Close. Lambeth Council's lease on these properties expired, and the residents in Limerick Road were re-housed from there in April 2008. This paved the way for squatters to move in to these addresses.

552. In response to the squatters taking up residence, the housing management company that owned the properties began the lengthy legal proceedings to have them evicted. These proceedings culminated in their eviction on 27 August 2008.

553. Immediately following the death of Mr Rigg, the IPCC decided to carry out a leaflet drop to addresses in the area. These leaflets were appealing for witnesses who saw Mr Rigg and/or the police and the interaction between the two.

554. The parameters for this witness appeal were set beforehand, and because Limerick Close was two streets away, it was decided that it would not form part of the leaflet drop. This witness appeal took place on 22 August.

555. Should the IPCC have wished to, we had plenty of opportunity to speak to the residents of Limerick Close before they were evicted on 27 August. We chose not to, and therefore the implied criticism of the police for allowing the squatters to be evicted without questioning them about Mr Rigg is misplaced.

556. The eviction of these squatters had no impact on the IPCC's investigation.

<u>In the weeks following Mr Rigg's death, officers attempted to interfere with the IPCC investigation by contacting staff at the Fairmount Road hostel.</u>

557. This forms part of the original Rigg family complaint. There are allegations of police interfering with the IPCC investigation by police officers approaching staff at the hostel asking them what they knew about the events following Mr Rigg's departure from the hostel. Also what they knew of the progress of the IPCC investigation.

558. This was also mentioned at the meeting between the family and the IPCC on 22 September 2008.

559. No further details were provided by Mr Rigg's family regarding the names of the officers involved, who they had spoken to or what specifically they had said.

560. As with some of the other issues raised by Mr Rigg's family, this specific complaint did not form part of the terms of reference for this investigation. Having said this, Ms Wood was spoken to about this particular issue.

561. On 10 February, Ms Wood was visited by Deputy Senior Investigator, Colin Dewar. One of the issues discussed was the visits made by some police officers to the hostel in the aftermath of Mr Rigg's death.

562. Ms Wood did recall some officers calling after Mr Rigg died. She says that she felt they were visiting mainly to enquire about people's welfare. Ms Wood says that there were some questions about what happened on 21 August, but the officers' behaviour was not untoward in any way.

563. It is difficult to see how these visits from the officers could realistically have interfered with the IPCC investigation. All the witnesses from the hostel had been interviewed and statements taken within 10 days of Mr Rigg's death. When interviewed, none of these witnesses complained about police officers pressurising or coercing them in any way.

564. There is no doubt that some officers did visit the hostel following Mr Rigg's death, and this may have caused some frustration for Ms Wood in that when she needed the police, on 21 August, none were available. Having said this there is no evidence to suggest that the officers' motives were underhand in any way.

<u>The police interfered with Mr Rigg's mobile phone after he was taken to hospital.</u>

565. Following Mr Rigg's death, the police needed next of kin details in order to make his family aware.

566. At approximately 9pm, Brixton police contacted Mr Stevens in order to obtain next of kin information. Mr Stevens provided the police with a phone number, but wasn't confident about its validity. Mr Stevens said that,

"I was concerned about the next of kin number because it appeared incorrect and told them this".

567. The police again contacted Mr Stevens later that evening at approximately 12.10am regarding the next of kin. Mr Stevens had no further details to provide and suggested they contact the office in the morning.

568. At approximately 2.15am Mr Stevens received a call from the night staff at the hostel. He was informed that the police were at the hostel trying to obtain next of kin details.

569. The hostel member of staff allowed the police access to Mr Rigg's room. One of these officers was DC Laura Manz. She notes in her family liaison log that she found a mobile phone on the bedside unit. DC Manz noticed that the battery was low and therefore wrote down the contact numbers for Mum and Wayne. She also looked into the text messages and saw a recently sent one from Samantha Rigg.

The message said "hello bruv" so she recorded this number also. DC Manz then looked in the contacts, and found another number for Samantha 2. DC Manz removed the mobile phone and charger from Mr Rigg's room. The hostel staff were asked to make a note of what the police had taken.

570. On 23 August, the police Family Liaison Officers (FLO) met with the IPCC Family Liaison Managers (FLM). At this meeting, Mr Rigg's mobile phone and charger were handed to Mr Richard Omotosho (FLM).

571. Later that afternoon, Mr Omotosho gave the mobile phone and charger to Ms Samantha Rigg.

572. There is no evidence to suggest that the police contact with Mr Rigg's mobile phone was any greater than that outlined above.

Why did it take so long to interview the officers who were involved in the arrest.

573. This particular question has been a constant theme of family discontent throughout the course of the investigation. This general question has also been further qualified by Mr Rigg's family, both face to face in meetings, and by correspondence.

574. In a list of questions sent to the IPCC on 14 January 2009, the Rigg family asked,

"Why has the IPCC developed a practice whereby interviews of officers happen only at the end of an investigation…"

575. In a letter to the Commissioner dated 18 May 2009, the Rigg family

state,

"The IPCC refused to interview officers immediately as would have happened had Sean come to harm at the hands of members of the public".

576. The subject of when and how police officers provide their account of what happened can be a complicated issue. The IPCC has no set practice on how this happens as each incident and each investigation is different and therefore decisions need to be made based on the individual and unique set of circumstances.

577. Generally speaking, following an incident of this nature a decision needs to be made as to whether the officers involved are to be treated as witnesses to the incident, or as suspects of some form of criminality or misconduct.

578. If they are witnesses, the IPCC would endeavour to obtain their account of what happened as soon as possible, as with any other type of witness.

579. This account can be obtained in one of three ways.

- The officer concerned can be asked to provide a witness statement written by them.
- The officer can be interviewed by an IPCC investigator and a witness statement completed on their behalf for them to sign.
- The officer can be interviewed by IPCC investigators as a "significant witness". This interview will be at least audio recorded, and if facilities allow, video recorded in order to achieve the best evidence possible.

580. If an officer is to be treated as a suspect, then, as per the Police and Criminal Evidence Act 1984 (PACE), there would need to be grounds to suspect them of having committed a criminal offence. To satisfy this test there would need to be, in accordance with Code C

of PACE, some “reasonable, objective grounds for such a suspicion based on known facts or information which are relevant to the likelihood the offence has been committed and that the person to be questioned committed it.”

581. They would be entitled to legal advice and would be given pre-interview disclosure of information relating to the incident.

582. In short, they would be afforded all the rights and protection given to any member of the public who is suspected of a criminal offence.

583. The timing of these suspect interviews would again depend on the unique circumstances of the incident being investigated.

584. One option is for the suspected officer to be interviewed early in the investigation. The benefit of this is that any account obtained from the officer may inform the investigation and focus certain lines of enquiry or indeed open up new ones.

585. One of the drawbacks is that there may be a necessity to interview the officer for a second time further into the investigation once evidence has been obtained.

586. Another option is for the suspect to be interviewed at an appropriate point later in the investigation. This will enable the investigation to obtain evidence relating to the incident and the specific allegations against the officer. This will therefore allow evidence to be put to the suspect during the course of the interview.

587. As mentioned above, there is no set practice for when to obtain an account from a police officer. This decision of how and when to do this belongs to the senior investigator.

588. The following paragraphs will now examine the circumstances that led to the interviews of the police officers involved in the arrest of Mr Rigg.

589. On 22 August, the day after Mr Rigg's death, three of the four officers involved provided witness statements to inform our investigation. Following a serious incident of this nature, it is often the case that the officers involved will provide a statement (usually brief) to provide investigators with the information they require to meaningfully progress the investigation.

590. These statements provided an outline of the circumstances of Mr Rigg's arrest and subsequent transportation to, and detention at Brixton police station.

591. They greatly assisted the investigation, but the accounts of the officers needed to be substantially expanded upon.

592. On 26 August 2008, the IPCC senior investigator decided that the four officers who were involved in the arrest of Mr Rigg would be treated as witnesses. The reasoning for this being that the post mortem showed no evidence of assault, and from the information available at the time it seemed that the arrest was justifiable. The early part of the investigation had attained no evidence to suggest any wrongdoing on behalf of the police officers.

593. A decision of this type remains constantly under review and may be subject to change depending on the evidence acquired.

594. On 28 August, the officers' status was reviewed by the senior investigator, and he decided that the officers could no longer be treated as witnesses. It was felt that after reviewing the custody suite CCTV footage, it would be reasonable to expect the officers to have noticed a change in the demeanour of Mr Rigg.

595. Having said this, the uncertainty cast over the officers' actions was not of sufficient strength to warrant the issue of Regulation 9 notices (notices informing the officers of the alleged misconduct and notifying them of their rights). At this stage the senior investigator

did not have sufficient information to be able to definitively decide the status of the officers. This is documented in his policy log entry of 2 September.

596. On 15 September, the status of the officers was once again reviewed. It was decided that all the police officers involved in Mr Rigg's arrest would be treated as significant witnesses.

597. The term significant witness denotes a witness whose evidence (usually eye witness testimony) is key to the incident that is being investigated. It is a decision of the senior investigator exactly who will be designated as a significant witness.

598. The decision to treat the officers as significant witnesses was based on the available CCTV evidence, an account from an independent witness who saw the arrest and the pathological evidence so far obtained.

599. Arrangements were then put in place to interview these officers. Appointments were made for the officers to be interviewed as witnesses on 17 October 2008.

600. On 12 October, the IPCC received the complaint from the solicitors representing Mr Rigg's family. There were specific allegations in this complaint accusing the officers of criminal activity ranging from serious assault to activity that, if proved, would effectively amount to misconduct in public office. The complaint also stated that the family believed the officers' behaviour made them suspects in the murder or manslaughter of Mr Rigg.

601. Following receipt of these serious allegations the status of the officers had to be reviewed once again. On 17 October, the senior investigator, having taken legal advice, decided that the officers now needed to be treated as suspects in this investigation and therefore the witness interviews were cancelled.

602. In simple terms, the reason they could no longer be interviewed as witnesses was because like any member of the public, when under suspicion of a crime, any account given by the officers would have to be preceded by a criminal caution.

603. The investigation continued and on 12 November, a statement was taken from an independent witness. This witness stated that one or more of the officers assaulted Mr Rigg during his arrest.

604. Up to this point the investigation had uncovered no evidence to substantiate the criminal allegations made by the Rigg family. The testimony provided by the independent witness amounted to a potential offence of Common Assault. Common Assault is a summary offence and therefore criminal proceedings must begin within six months of the alleged offence being committed.

605. The officers needed to be interviewed to be given the opportunity to answer this allegation. The time limit for the commencement of legal proceedings was 20 February 2009, and therefore the interviews needed to take place well before this date in order to give the Crown Prosecution Service (CPS) time to make a decision regarding any potential prosecution.

606. The four officers were interviewed under criminal caution on 19 January, 21 January, 22 January and 26 January 2009.

607. On 16 January, it was decided that the parameters for these interviews would be set solely around the allegation of assault made by the independent witness. The interviews would cover the period from when Mr Rigg was assisted to his feet by the officers to when he was placed in the back of the police van. It was decided that should the investigation require, the officers would be interviewed at a later date regarding any other issues relating to 21 August.

608. On 13 February, the decision was received from the CPS stating

that they did not intend to prosecute any of the officers for Common Assault.

609. Following this decision, the evidence attained so far by the investigation was reviewed. It was decided that there was no evidence to suggest that any other criminal offence may have been committed by the officers. There was no evidence to substantiate the serious criminal allegations made by the family of Mr Rigg.

610. Following this review, on 25 February, the senior investigator decided that the investigation would no longer be a criminal investigation. Therefore the officers would not be further interviewed under a criminal caution, they would be interviewed as part of potential police misconduct proceedings.

611. These misconduct interviews took place on 18 March and 26 March.

612. The above is an explanation of the circumstances that led to the interviews of the officers. It proved to be an unusually lengthy and complicated process and by no means an ideal one. But ultimately this investigation was provided with the accounts of the officers concerned.

The manner in which the family was treated immediately following his death.

613. Although this particular grievance did not form part of the original family complaint, it is specifically mentioned in the family solicitor’s letter to the IPCC Commissioner dated 18 May 2009.

614. In this letter the solicitor states that the sister of Mr Rigg, Ms Samantha Rigg, was notified of her brother’s death at approximately 3.30am on 22 August. This was done by two police Family Liaison Officers.

615. These FLOs said that Mr Rigg had collapsed at the police station and died in hospital. They said they would *“drip feed”* the family

information, and said that Mr Rigg was *"in a body bag"* and that his body was effectively a crime scene. According to the family, they had to probe the FLOs in order to receive a reason why they wished the family to sign a medical consent form. They said that the FLOs offered no advice or support.

616. The family also state that they phoned the Coroner's Office on the evening of the 22 August, where they only managed to get an answer phone. They say that by this time they had still received no contact from the IPCC, and the handover that was due to happen between the FLOs, never occurred.

617. The hours following the death of someone in custody are an extremely difficult time for all concerned. For the family, the news of the death of a relative can only be described as shocking and traumatic.

618. In circumstances such as these, the FLO has an important role to play.

619. According to the Association of Chief Police Officers (ACPO) Family Liaison Strategy, the role of the Family Liaison Officer is four fold.

- *To provide care, support and information in a sensitive and compassionate manner to the family who are themselves victims of crime.*
- *To ensure that family members are given information about support agencies and that referrals are made to Victim Support and other agencies in accordance with the family's wishes.*
- *To gather evidence and information from the family in a manner which contributes to the investigation and preserves its integrity.*
- *To secure the confidence and trust of the family thereby enhancing their contribution to the investigation.*

620. If the FLOs used the terminology as described by the family, then it would appear that this element of contact with the family may not

have been handled as sensitively as it might have been.

621. The particular issue of the police family liaison did not form part of the terms of reference for this investigation and therefore has not been investigated. Suffice to say that if the family's recollections of the hours following Mr Rigg's death are accurate, then according to the policy above, they did not receive the service that they perhaps could have expected.

622. The role of the IPCC Family Liaison Manager is different to that of the police FLO. The IPCC Family Liaison Policy states that this difference is *significant,* and goes on to say that this is because,

…in most cases there will not be an outstanding suspect and this will have a considerable influence upon family management and their involvement in the investigation.

623. Mr Rigg's family assert that following their failed attempt to contact someone at the mortuary, they had still had no contact from the IPCC. With regard to this point, the family's recollections are incorrect.

624. The IPCC FLM, Mr Omotosho, had a 10 minute telephone conversation with Ms Samantha Rigg on the afternoon of 22 August, at approximately 2.10pm. They discussed the impending IPCC press release, and how the family wished Mr Rigg's ethnicity to be described.

625. IPCC Deputy Senior Investigator, Chris Patridge, had contact with the family's representative, Mr Paul Rees-Taylor on the evening of 22 August. Mr Patridge informed Mr Rees-Taylor at 6pm, that the post mortem was running late, and that he would inform him when the procedure had concluded.

626. When the post mortem finished, Mr Patridge was informed by the Coroner's Office that it would not be possible for the family to see Mr

Rigg until Tuesday 26 August, because it was a bank holiday weekend.

627. Understandably, this would have been an intolerable delay for the family to endure. Throughout the course of the evening of 22 August, Mr Patridge was in contact with the Coroner's Office in an attempt to broker a more satisfactory arrangement for the family. Through Mr Patridge's intervention, a viewing was arranged for the morning of the 23 August. Mr Patridge then telephoned Ms Samantha Rigg on the evening of 22 August to inform her.

628. In the family's letter of 18 May, there is some implied criticism of the IPCC and/or Mr Patridge in relation to the viewing of the body. The decision regarding when and how families get to view the bodies of their relatives, rests solely with the Coroner and the Coroner's Office.

629. The IPCC has no say in this matter, except to explain the relevant circumstances to the Coroner's Office in order for them to be able to make an informed decision about viewing.

630. With regard to the handover from the police FLOs to the IPCC FLMs, the following was decided. The FLMs met with the FLOs to arrange the formal handover of responsibilities from one to the other. At this meeting it was felt that there was no need for the police to formally introduce the IPCC to Mr Rigg's family. This was because the FLOs had had little contact with the family to date and Mr Omotosho, IPCC FLM, had already spoken to Ms Rigg. At the meeting on 23 August, between Mr Rigg's family and the FLMs, the reason for the police FLOs absence was explained.

<u>The delay in interviewing the 999 call handlers.</u>

631. The part the call handlers played in the events of 21 August, is integral to the investigation into the death of Mr Rigg. Their actions

underpinned the police response to the circumstances as they unfolded on the evening in question and formed part of the terms of reference for the investigation.

632. Ideally, the call handlers would have been interviewed earlier in the investigation than they actually were. Similar to the police officers' situation, the call handlers were issued with "Notices of Investigation" informing them of their rights and the potential misconduct for which they were being investigated.

633. This meant that the call handlers would not be interviewed as witnesses, and therefore the issues of their rights, representation and pre-interview disclosure would all contribute to making the process lengthier than it would otherwise had been.

634. There was also a need for this investigation to prioritise its lines of enquiry in order to maximise the evidence gathering opportunities.

635. It was deemed less imperative to obtain the evidence of the call handlers at an early stage. The reason for this being that the interaction between the call handlers and the staff at the hostel who dialled 999 was all captured on tape. This evidence was therefore secured at a very early stage of the investigation. The CADs that were raised for these calls have also been in the possession of the IPCC since the beginning of the investigation and therefore the integrity of this evidence has been preserved.

636. As the investigation progressed, the emerging picture was that the actions of the call handlers were neither criminal nor did they constitute misconduct. The "Notices of Investigations" previously issued were rescinded and the decision was made to interview the call handlers as witnesses.

Finding 1

637. The CCTV system in operation at Brixton Police Station in August 2008, was not in full working order. The management of this system was inadequate and contributed to its lack of full effectiveness. The full details of this can be seen in the CCTV report at Appendix B.

Local recommendation

638. The CCTV system at Brixton Police Station should be fully reviewed. The management of the system needs to be simplified, and someone appointed as the responsible officer. Faults should be repaired.

Response by force

639. CCTV system is checked at the daily meeting with IBO BOS. This enables faults to be identified and reported in a more timely fashion.

640. CCTV system at Brixton Police Station is now digital.

Finding 2

641. 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.

National recommendation

642. Police forces should review the carriage of detainees in caged vans and ensure that detainees in transit are monitored at all times.

Appendix A

Report into Complaint made by Ms Angela Wood

Background

643. Mr Sean Rigg was a resident at the Penrose Housing Authority Focus Project at Fairmount Road, Brixton, London SW2. This project offers support and guidance to individuals with mental health issues.

644. At approximately 4.53pm on 21 August 2008, a 999 call was made by a member of the project's staff to say that one of their residents, Mr Rigg, was behaving strangely.

645. The member of staff stated that Mr Rigg, who was a diagnosed schizophrenic, was showing signs of a breakdown. He went on to say that he was advancing towards staff in a threatening manner.

646. Two further 999 calls were made at 5.32pm and 6.46pm. The callers stated that Mr Rigg was still behaving in a threatening manner. Although he had not hurt anyone, his behaviour continued in a similar vain until some time between 7pm and 7.15pm.

647. At this time Mr Rigg left the hostel and walked along Brixton Hill. Two further 999 calls were made by members of the public saying that a man (Mr Rigg) was attacking people in the street. These calls were made at 7.29pm and 7.30pm.

648. A police unit immediately responded. Mr Rigg was arrested at approximately 7.40pm and transported to Brixton Police Station. A little over 20 minutes after his arrival, an ambulance was called for him and he was taken to Kings College Hospital where he was pronounced dead at 9.24pm.

649. Following Mr Rigg's arrest a further 999 call was made by the manager of the Fairmount Project, Ms Angela Wood. She was not at the hostel when she made the call, but was aware that Mr Rigg had left the premises. Ms Wood was phoning on behalf of her distressed staff, who believed they were not receiving any response from the police with regards to their earlier 999 calls.

650. Ms Wood made her call at 7.52pm where the operator she spoke to was Mr Maurice Gluck. Ms Wood attempted to explain the seriousness of the situation to Mr Gluck, but she felt she did not receive the appropriate level of service from Mr Gluck. On 28 August, Ms Wood made a complaint.

Complaint

651. On 28 August, Ms Wood made her complaint by e-mail to the Lambeth Borough Commander, Chief Superintendent Sharon Rowe.

652. In her e-mail she outlines her complaint which is two fold. Firstly, she complains that she found it,

"unbelievable that an emergency call that was made at 16.53 is ignored until 20.12".

She goes on to say that in her opinion it was,

"an inexcusable length of time for the public to wait for police assistance in an emergency……….I am staggered and angered at this response and I do wholeheartedly believe that had your team chosen to listen to me and my team from 16.53 Mr Rigg would be alive today".

653. This part of Ms Wood's complaint is being address within the main investigation report.

654. The second part of her complaint involves the actions of the call handler Mr Gluck.

655. Ms Wood states that the member of police personnel (Mr Gluck) who dealt with her call at 7.52pm,

"displayed a level of ignorance and arrogance that was shocking and angered me greatly".

656. She expands on this by saying,

"The response from a member of your team (Mr Gluck) clearly demonstrates a complete disregard for public safety, mental health issues and an inability to gather information and act appropriately. Your team member's response made me feel that the police felt that we were overreacting and ultimately were being a nuisance".

657. Within her complaint Ms Wood goes on to describe in some detail her interaction with Mr Gluck which led to her requesting a formal investigation into the conduct of the call handlers.

Conclusion

658. The role of the call handlers on the 21 August, and in particular Mr Gluck, can be divided into two distinct parts. Firstly, how the

information was taken and responded to, and the impact it had on the police contact with Mr Rigg. Secondly, the alleged incivility by Mr Gluck during his conversation with Ms Wood.

659. The first issue will be dealt with in the main investigation report.

660. Mr Gluck handled the call made by Ms Wood at 7.52pm and raised CAD 8062. This call lasted approximately 6 minutes 20 seconds. The first thing to note is that by the time this call was made, Mr Rigg had been arrested and transported to Brixton Police Station. Therefore it is safe to say that the way Mr Gluck handled Ms Wood's call had no bearing on the way that the police interacted with Mr Rigg.

661. By the time Ms Wood makes her call, she is already unhappy with the way she perceives that the police had responded to the earlier 999 calls. She had previously called 999 at 7.19pm where CAD 7678 was raised.

662. Mr Gluck did not appear to make any attempt to placate Ms Wood and becomes embroiled in an argument with her on a number of issues. Mr Gluck eventually terminates the call when in his view, he and Ms Wood appeared to be going round in circles. At that stage that was not an unreasonable observation.

663. Although it is accepted that Mr Gluck was faced with a dissatisfied and challenging caller, he does not appear to have handled the call as professionally as he ought. His attitude could be described as condescending or dismissive, and it is easy to understand Ms Wood's frustration that led to her complaint.

Appendix B

Brixton Police Station CCTV Report

Introduction

664. On 21 August 2008, Mr Sean RIGG was being transferred from a police van, parked in the rear yard of Brixton Police Station, to the custody suite via the holding area (cage). Mr Rigg remained in the cage area until he was taken to an ambulance and transported to hospital where he was pronounced dead.

665. IPCC Investigators attended the scene, and at 4.05am on 22 August, the Custody CCTV was seized. This was done by an officer from the Department of Professional Standards in the presence of an IPCC Investigator, and sealed in an exhibit bag.

666. On 3 September 2008, it was confirmed that some CCTV cameras located in the rear yard of Brixton Police Station did not form part of the Custody CCTV. This included a camera that would have covered the holding cell and potentially the area the police van was parked. These cameras were identified as being part of the Security CCTV System and on 16 September, attempts were made to obtain footage from these cameras. It was found that on 21 August some of these cameras were not working. Furthermore, there was no footage from these cameras for the previous three months which is as far back as the data would be held. This

suggests that these cameras had not been working for a significant amount of time.

667. This report will look at the CCTV systems at Brixton Police Station, focussing on why part of the rear yard and holding cell were not covered by Custody CCTV and why some of the Security CCTV cameras were not working on 21 August.

Brixton CCTV Systems

668. There are two different CCTV systems at Brixton Police Station, the Security CCTV system and the Custody CCTV system.

Custody CCTV

669. The Guidance on the Safer Detention & Handling of Persons in Police Custody 2006 says:

> *Forces should establish policy stating the purpose of the CCTV system…It is anticipated that CCTV will have two functions in custody suites: the protection and welfare of all users of custody, and the prevention and detection of crime.*

670. Below is an extract from Metropolitan Police Service Custody Suite CCTV Policy:

> *The primary purpose for the installation and use of custody suite CCTV systems is to assist in the management of the detention of prisoners. It is recognised, however, that custody suite CCTV images and sound recording will occasionally be required for evidential purposes.*
>
> *The CCTV system will help provide safeguards for police, prisoners and all others involved in the detention of prisoners. This will be achieved by;*

Providing an almost indisputable record of the escorting, initial reception, booking in and detention of the arrested person;

Recording the physical condition of the prisoner and compliance with statutory requirements under the Police and Criminal Evidence Act 1984 (PACE);

Reducing incidents of violent or disorderly behaviour by prisoners in the custody suite and discouraging malicious complaints and allegations; and

Where appropriate, visual monitoring of prisoners in cells equipped with CCTV.'

671. Brixton has 30 Custody CCTV cameras which link into a multiplex system. The multiplex system is a device that allows outputs from a number of cameras to be coded into one signal which can then be recorded on to a single storage format such as a video tape.

672. The Custody CCTV viewing monitors and recording equipment are located in the Custody Suite. The system consists of a multiplexer linked to a bank of three video cassette recorders. At any one time only one VCR will be recording. This system allows a continuous recording 24 hours a day to be taken.

673. The multiplexer also links to a monitor which shows a view from all the cameras on a split screen. At Brixton Police Station there are a number of monitors showing the camera views.

674. The Custody CCTV is maintained and operated by Clearview Communications, an approved contractor.

675. The Metropolitan Police Service Custody Suite CCTV Policy outlines a Certification of Operation procedure. Each videotape produced by a custody CCTV system must be individually identifiable and accounted for. At the beginning of each tour (or a specified time)

the Custody Officer or their deputy must certify that the system is working and if the system appears defective the engineers must be called immediately. The custody officer may delegate this task to the gaoler but accountability remains with the custody officer. The system may be certified as working correctly if all of the following are correct:

- One of the VCRs indicates it is recording; and
- there are unused videotapes in the other two VCRs; and
- the large monitor in the custody suite shows that all cameras are operating (that is, there is a clear picture on each).

Responsibility for the Custody CCTV

676. The Guidance on the Safer Detention & Handling of Persons in Police Custody 2006 says:

Forces should ensure that clear lines of responsibility for the ownership and administration of the system are established, including responsibility for day to day operation, the integrity of the system and any recorded footage. A fault reporting procedure and maintenance programme should be included to ensure that the operational availability is maximised.

677. Below is an extract from Metropolitan Police Service Custody Suite CCTV Policy regarding the roles and responsibility of staff

<u>System manager:</u>

The BOCU senior management team (SMT) should appoint a member of staff to have overall responsibility for the management of the custody CCTV system and tapes.

<u>Systems administrator/librarian:</u>

A member of the BOCU staff will perform the role of systems administrator / librarian. This will help in achieving a consistency of

approach to tape management within the BOCU. In addition it will also introduce an independent element, thereby protecting the integrity of the system. They will be responsible for:

the reception, logging and accounting of all borough custody CCTV tapes to maintain an audit trail;

assisting officers with technical advice regarding the viewing and reproduction of tapes;

answering correspondence and telephone enquiries regarding these matters; and

ensuring the correct storage of CCTV tapes and maintaining the borough tape library.

Custody staff:

The custody officer at each site is responsible for ensuring the system is functioning correctly and that sufficient videotapes are available for use. This function may be devolved to the gaoler but overall responsibility rests with the custody officer.

678. The responsibilities of the Custody Officer, System Manager and the Systems Administrator/Librarian are to ensure that the Custody CCTV system is working correctly. On the 21 August 2008 the Custody CCTV system was working correctly and continuous images were captured from all available cameras.

Custody CCTV Locations and Policy

679. The Guidance on the Safer Detention & Handling of Persons in Police Custody 2006 says that;

Forces must decide on the areas that the CCTV should cover and lists a number of areas where CCTV coverage should be considered, this includes the vehicle docking area, holding areas

and entrance to the custody suite.

680. Below is an extract from Metropolitan Police Service Custody Suite CCTV Policy:

The arrangement and positioning of custody CCTV cameras and recorders varies according to the needs of each custody suite.

Each custody suite CCTV system is designed to cover all common areas within the custody suite and certain external locations such as the entrance to the custody suite.

681. Custody CCTV at Brixton Police Station comprehensively covers the areas inside the Custody Suite including inside the entrance lobby, booking in area, cells and corridors.

682. There are two external Custody CCTV cameras in the rear yard of Brixton Police Station. One CCTV camera is located above the rear gate facing towards the holding cell and the other is located in the main building providing coverage of the area between the rear gate and the main building.

683. There also used to be a third camera that was located on a building that has now been demolished. This camera would have covered the holding cell and surrounding area.

684. It is likely that when the building was demolished the camera was removed. The input into the multiplexer and monitor has been replaced with another input from Camera 2. This is why the Custody CCTV multiplexer and monitor show two views from Camera 2.

685. This has left an area of the rear yard not covered by Custody CCTV. It is not immediately obvious from looking at the monitor in the Custody Suite that this camera has been removed, as there are no blank screens.

Security CCTV

686. The Security CCTV forms part of the physical security for the building. It is separate from the Custody CCTV system, although it is possible for a single camera to input into both the Custody CCTV and the Security CCTV

687. At Brixton Police Station, Security CCTV cameras link into the Genesys Building Security Management System, a digital recording system that also integrates a number of other electronic security systems into one interface. This interface is a touch screen monitor located in the Integrated Borough Operations Unit room. This is not viewable within the Custody Suite.

688. Most of the security cameras are located in the front office of Brixton Police Station with the remaining covering the perimeter.

689. The camera numbering is not consistent and often the cameras are referred to by the number they are given on the monitor. However, it is clear that there are three external Security CCTV Cameras located in the back yard of Brixton Police Station:

- Camera 18 (sometimes labelled 2 or 5) is located to capture individuals and vehicles entering the yard through the rear gate. This would use the same camera as Camera 2 in the Custody CCTV;
- Camera 3 looks out over the bike sheds.
- Camera 4 covers the area police vehicles park and the holding cell. It is possible that camera 4 would have covered the area where the van transporting Mr Rigg parked and may have captured him being conveyed to the holding cell.

- There is a further camera located on the gate to the back yard, which is also monitored and recorded through the Genesys system.

690. On 21 August 2008, Camera 4 on the Security CCTV system was not recording. It has since been established that there was a fault in the cabling, this has now been rectified. Camera 18 was also showing a not recording and Camera 3 was recording a very poor picture. As of 2 March 2009, these cameras were still not working.

691. There are systems in place to rectify faults. These are outlined below.

Maintenance of the Security CCTV systems

692. It is the responsibility of the user on site to report a fault in the Security CCTV system.

693. The reporting of all Electronic Security System faults at Brixton Police Station falls into two areas of responsibility, Retained systems and Outsourced systems.

694. The Custody CCTV is classified as Retained and is maintained by the Metropolitan Police Service (MPS) approved contractors.

695. The Security CCTV cameras are classified as Outsourced and are maintained by third party contractors, Interserve.

696. However, this is complicated by the fact that the Security CCTV system is recorded and viewed on the Genesys Building Security Management System, this Genesys system is classified as Retained.

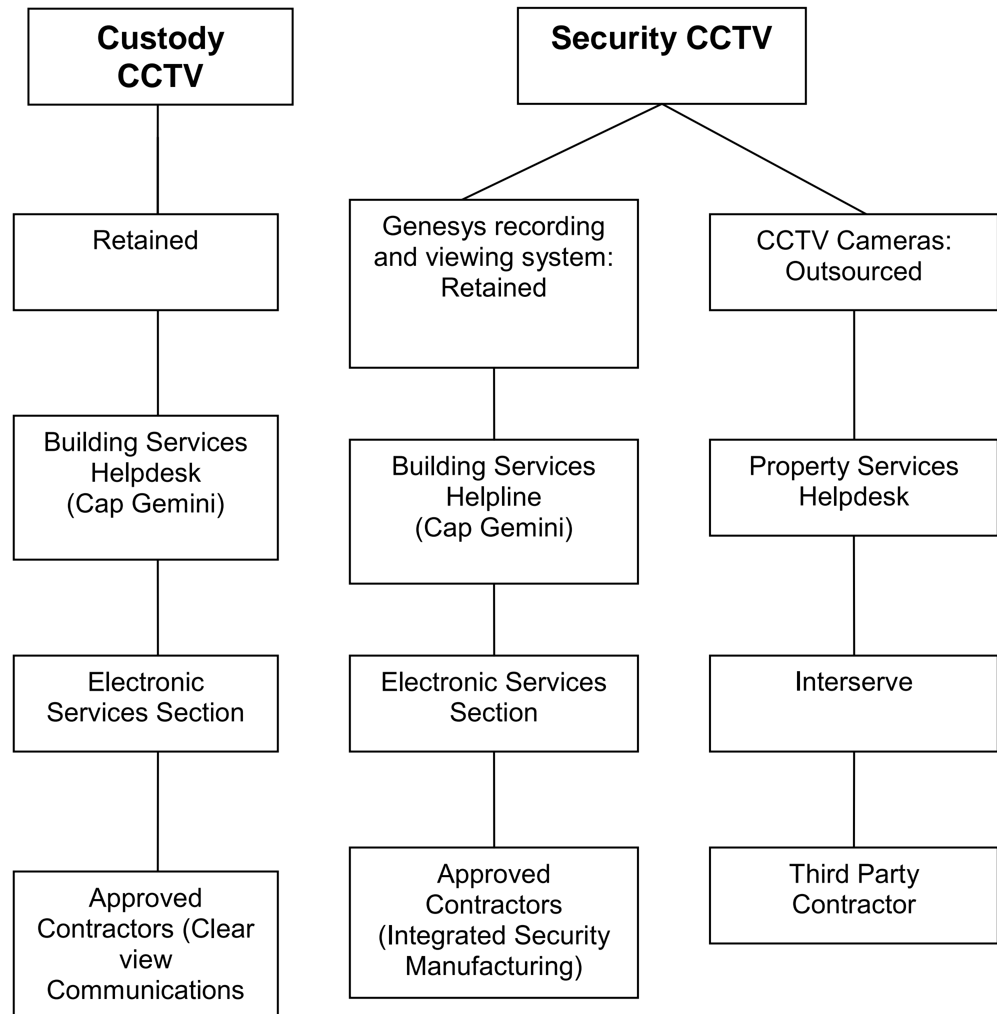
697. Faults in Retained and Outsourced systems are dealt with through different processes.

698. Faults within the Retained systems are reported to the Building Services helpdesk operated by Cap Gemini who pass the call

through the DOI(7), ESS (Directorate of Information, Electronic Security Section - formerly known as the OTSU - Operational Technical Service Unit) and organise the rectification of the fault through approved contractors. The approved contractor for the Genesys system is Integrated Security Manufacturers, ISM.

699. Faults within the outsourced system are reported to the Property Services Department helpdesk who pass the call on to Interserve who will deal with the fault via third party contractors.

700. This diagram shows the fault reporting process for both Retained and Outsourced systems:



701. The helpdesks should screen the calls when they are received. If a fault is reported to the wrong helpdesk it should be forwarded to the correct helpdesk. However, it is not always clear which system the fault is with and contractors may have to attend to establish whether it falls under their remit.

702. Although the physical maintenance of the systems and call handling is contracted out, DOI(7), ESS retain overall control of all security and technical systems. Should there be an urgent request or a particular issue of interest, they can bypass this reporting system

and send contractors to rectify the fault.

Reported faults relating to the Security CCTV cameras (Outsourced)

703. Records were obtained from the Property Services Department showing all faults that were reported from the start of 2008 until September 2008. The records show a number of requests but none of these refer directly to faults with the Security cameras in the back yard of Brixton Police Station.

Reported faults relating to the Security CCTV on the Genesys System (Retained)

704. Cap Gemini are contracted to operate the Building Services Helpdesk. They will receive the initial calls from the user regarding retained systems and pass the call onto the appropriate contractor via the DOI(7), ESS to rectify the problem. ISM are the company that install and maintain the Genesys viewing and recording system.

705. Records have been obtained that show faults with the Security CCTV and the Genesys viewing and recording system were reported to Cap Gemini on 19 May 2008 (Job No. 1426060) and 23 July 2008 (Job No. 1562041).

Job Number 1426060

706. Cap Gemini records show Job No. 1426060 as:

user called to outline the cctv monitor is not showing that cameras 3 and 8 both views gone down.

707. Cap Gemini informed the contractor who maintains the Genesys System, ISM, who attended this job.

708. ISM engineers established that the faults were with the cameras. As

the cameras are classified as Outsourced equipment, ISM referred the fault back to Cap Gemini, who would pass the fault through the Outsourced fault reporting process. However, on this occasion the DOI(7), ESS were aware that there was an issue and referred it straight to Cam-tech.

709. Cam-tech engineers attended on 22 May 2008 and replaced a PSU (Power Supply Unit) which fixed camera 8. Camera 3 had a faulty coax cable and this was replaced on 23 June 2008. The functions were tested and are recorded as working.

Job Number 1562041

710. Cap Gemini records show job number 1562041 as *'faulty camera'*.

711. Cap Gemini informed ISM who attended this job. ISM records show the fault reported as *'Camera's faulty on Genesys'*. The ISM work docket from an engineer who attended this job says:

Cameras 8, 13, 11 in the front office; camera 17 in the main entrance; and camera 2, an external camera were not working and that camera 3 in the yard has a bad signal.

712. The work docket does not directly refer to a fault with camera 4, the camera which may have captured the holding cell and surrounding area, although the camera numbering is not reliable. However, it does identify that faults existed in external and yard cameras as well as the cameras in the front office.

713. ISM identified that the fault was with the cameras, which are an outsourced resource. Therefore the job was referred back to Cap Gemini to pass down the Outsourced fault reporting process. Once again DO17, ESS were aware that there was an issue and referred it straight to Cam-tech.

714. A Cam-tech engineer attended on 24 July 2008. The service report

says, *'Cam/faults front office. Replace P.S.U Cam desk (4) No feed to multiplexer cable fault (tem/set monitor to view'* and *'Cam feeds faulty 11,18,2,3,4,5,7?? Monitor feed new to front office for barrier. No feed?? cable faults'* and *'Revisit Required'*.

715. As previously mentioned, the camera numbers are not always reliable as they differ on different sources. However, this list includes numbers for cameras that are located in the rear yard – Cameras 18, 3 and 4.

716. The next day, 25 July 2008, an engineer attended Brixton. The service report says 'front office saying they have lost some cameras. Test all feeds to TER (Technology equipment room) and all cameras ok. Test back in front office and found all cameras showing but monitor on 16 way instead of 9 way so displaying 7 blank screens. Put onto 9 way and now ok'.

717. This service report only refers to cameras in the front office and does not make any reference to cameras in the rear yard. The Security CCTV cameras in the rear yard that were identified in the ISM work docket as having 'faulty cam feeds' have not been fixed. The service report also refers to testing the cameras in the front office on the monitor but makes no mention of testing the cameras on the Genesys system where they were originally reported as being faulty.

718. It appears that this engineer has not rectified all the previously identified by ISM and the first Cam-tech engineer.

Preventative Maintenance Reports

719. Preventative Maintenance Reports (PMRs) are an annual check of the Security CCTV cameras by Interserve, the contractor who is responsible for the maintenance of the outsourced systems. These yearly checks are an audit of the outsourced CCTV equipment and

should identify faults in cameras and certain outsourced viewing equipment.

720. Interserve arranged a PMR to be conducted by third party contractors Alarm Shop II. This took place on 12 August 2008, 9 days before the Mr Rigg died. The PMR by Alarm Shop II consists of one page which refers to five external CCTV cameras and two pages referring to internal CCTV. Having identified all the cameras noted in the report it seems likely that the page referring to the external cameras would have included the yard cameras. However, this is not clear as the reports do not identify which cameras are being looked at. The Alarm Shop II PMR makes no mention of any faulty external cameras.

721. The Genesys system does not have any recording for the relevant CCTV cameras going back three months. This would have included the date the PMR took place. It is not clear why this check did not pick up on the faulty cameras. The problem was later identified as a cable fault and was fixed by Alarm Shop II.

722. This raises questions over the effectiveness of the PMR provided by Alarm Shop II.

Conclusions

Custody CCTV

723. The current Custody CCTV system does not cover the external aspect of the holding cell and parts of the rear yard.

724. Originally there was a camera that covered this area but this was removed when the building it was located upon was demolished. The input was replaced with a duplicate view from an existing camera.

725. This has left an area of the rear yard not covered by Custody CCTV.

Maintenance of the Security CCTV

726. Security CCTV cameras including one which covered the holding cell were not working at the time.

727. It has been difficult to establish precisely why the cameras were not working. Faults with external cameras were reported but the same faults were not rectified when the final engineer attended.

728. An engineer has to rely on the information provided. If this information is not clear then there is potential that the fault will not be properly identified and rectified.

729. This report has highlighted that the fault reporting process is complex because the maintenance of CCTV systems is contracted out to so many different companies. The information is passed between a number of parties before the fault can be fixed and this increases the potential for a breakdown in communication.

Reporting faults

730. There is evidence that faults relating to cameras on the Security CCTV system were reported on two separate occasions. This is good practice by the force. However, having been to the Brixton Custody since the incident it is clear that other cameras on the system that were not working at the time are still not appearing on the Genesys system.

Preventative Maintenance Reports

731. The annual Preventative Maintenance Reports are an important

process to help maintain the integrity of the CCTV system; it provides a safety mechanism to catch any faults that have not been highlighted by users. The Preventative Maintenance Report, which took place nine days before the incident, failed to recognise any problems with the Security cameras. The report was inadequate.

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