INQUEST

Truth Justice Accountability

I can't breathe

Race, death & British policing

Full report

Unlocking the truth for 40 years

INQUEST
is an independent charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media, and parliamentarians. This is informed by 40 years of specialist casework which includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.

This report was researched and written by Raekha Prasad. It would not have been possible without the invaluable knowledge and work of the INQUEST casework team, as well as the policy team. Thanks also to Lucy McKay, Anita Sharma, Yohanah Rodney and Claire Campbell for their support.

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DEBORAH COLES
Director of INQUEST

For over four decades, INQUEST has worked with hundreds of bereaved families who have experienced the trauma and injustice of the death of a relative at the hands of police. The deaths of Black people have been among the most violent, neglectful, and contentious. A defining feature has been how quickly police resort to the use of force against Black men in particular.

INQUEST has a unique insight into the long-standing systemic issues arising from these deaths, across police forces and time. These include the brutal treatment of those who have died; the subsequent defensiveness their relatives face in the investigation processes and the associated trauma; and a culture of impunity, which has protected the individuals and institutions involved from being held to account and frustrated opportunities for meaningful change.

INQUEST seeks to challenge the harmful state narratives that deny, demonise, and dehumanise the dead and their families, to try and deflect attention from the violent reality of policing.

This report tells the human stories of Black men who have died, and their families' experiences in the aftermath. It evidences the deeply rooted patterns of racial disproportionality resulting in deaths after the lethal use of force. It also draws on the expert insight of some leading human rights lawyers.

The report shows how the failure to examine the potential role of race and racism in police related deaths renders it invisible and prevents effective action and accountability.

There have been countless campaigns, critical inquests, inquiries, and reports evidencing racist state practices in policing and the criminal justice system, and highlighting the repetition of deaths and some of the changes needed.

Despite this, there is a systemic indifference and denial by UK Government and police leaders of the reality of institutional racism in policing and beyond. Meanwhile, every year there are yet more violent deaths of Black people, and more families thrust into long and protracted fights for justice. This cannot continue.

Deaths following police contact are at the sharp end of a continuum of state violence and structural racism, which includes the heightened criminalisation, intensified policing, and disproportionate incarceration of Black and racialised people.

Racism institutionalised in police culture and practice equates Black people with 'dangerousness' and 'criminality'. These racialised tropes, stem from the colonial roots of modern policing.[a] This intersects with mental ill health, and the double discrimination faced by Black people.

[a] https://www.connectedsociologies.org/curriculum/policing/colonial-policing-comes-home/

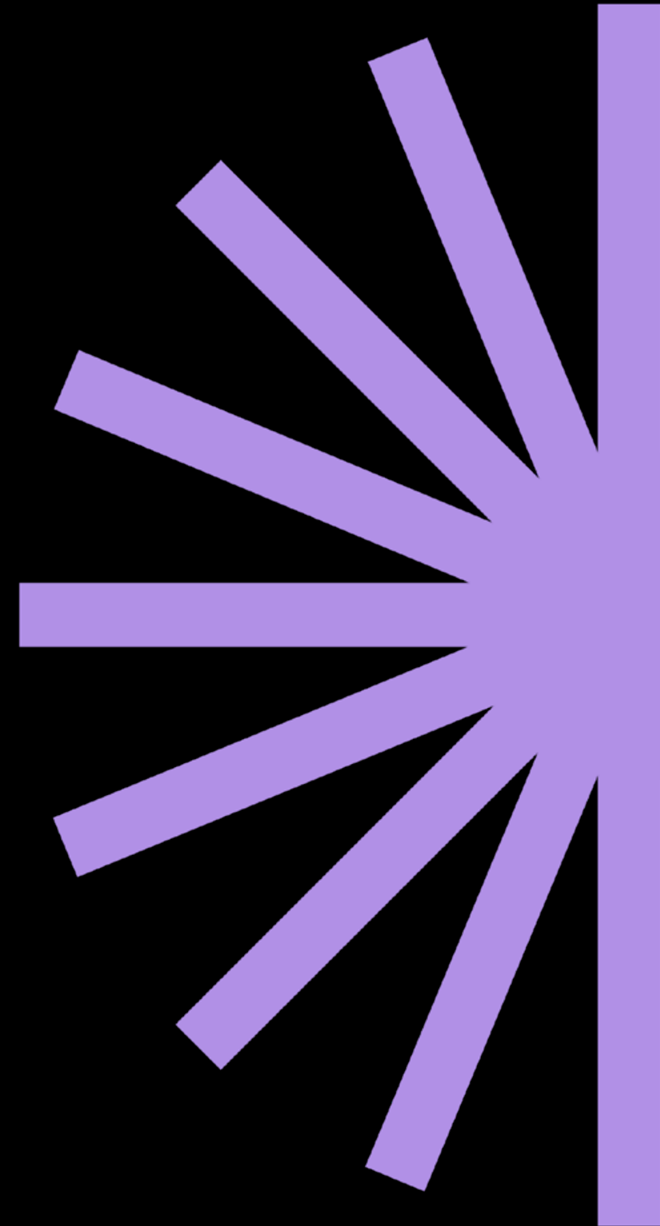
Policing has proven itself incapable of reform. Considering the broader social and historical context of contemporary policing, it becomes clear that effective and sustainable change must be systemic and transformative.

In the short term, we need better investigation and oversight of deaths to address racism in policing and public services and respond to repeated state failures. The post death legal processes must ensure bereaved families can access truth, justice, and accountability, s well as inform structural change to prevent future deaths.

In the long term we must situate these deaths within their broader social and political context. We must work towards a more just society and divert resources away from policing and the criminal justice system, and towards community, welfare, health, housing, education, youth services, and social care.

01

Executive summary



Executive Summary

The system of accountability for racism and racial discrimination in deaths of Black people following police contact is not fit for purpose. The police watchdog, inquests and the Crown Prosecution Service have historically failed - and continue to fail - to scrutinise the role that racial stereotyping might have played in these deaths, especially where excessive force is used. The result is that officers are not held accountable; there is no systemic learning and change and more deaths of Black people occur in similar circumstances.

The official data suggests Black people die at twice the rate of White people in or following police custody.

The government claims[1] that ethnicity does not impact "the likelihood of dying during or following police custody" because "Black people, in particular young Black men, are over-represented" in the arrest and detention data. This assertion can only be sustained because of the way such deaths have been categorised.

INQUEST has found from data never made public that **Black people are seven times more likely to die than White people** following the use of restraint in police custody or following contact.

Despite this stark racial disproportionality, none of the accountability processes effectively and substantially consider the role racism might have played in these deaths.

Black people are 7 times more likely than White people to die following police restraint

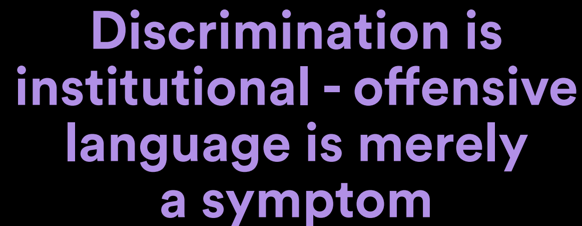
The role of racism in these deaths is not substantially scrutinised

Officers are not held accountable and there is no systemic change or learning

[1] Department of Health & Social Care, Home Office and the Ministry of Justice. (2021). Deaths in police custody: progress update 2021. Department of Health & Social Care, Home Office and the Ministry of Justice. Available at: https://www.gov.uk/government/publications/deaths-in-police-custody-progress-update/deaths-in-police-custody-progress-update-2021-accessible

The system of accountability is not working. The police are resistant to facing up to the reality of institutional racism and the IOPC lacks the political will to establish a framework, based on the current statute, that would deal with this persistent issue.

The idea that racism exists beyond explicit bigotry is not accounted for in the current bureaucratic and political structures. These are failing to recognise racism exists in a much deeper way in society that has roots in its power structures.



Furthermore, inquests are hindered by a lack of coronial racial awareness and a chronic inability to see racism being pertinent to the situation in which a Black person has died in police custody despite a wealth of evidence to suggest it is.

Discrimination is an institutional matter, of which offensive language is merely a symptom. While such deaths are seen by the investigatory authorities as isolated, individual incidents, Black people will continue to die at the hands of police.

IOPC

The cornerstone of police accountability is the Independent Office for Police Conduct (IOPC). Police forces are required to refer all cases where contact with officers may have caused or contributed to a death or serious injury to the IOPC. Despite their own internal figures pointing to disproportionality in the ethnicity data, **the IOPC has never concluded that a police officer has a case to answer for racial discrimination** when a Black person has died following police contact.

The IOPC, a non-departmental public body[2] sponsored by the Home Office, is required "by law to secure and maintain public confidence in the police by ensuring the police are accountable for their actions and lessons are learnt." If the watchdog is judged by this measure on the issue of racism and deaths following police contact, it has failed.

Using Freedom of Information requests, INQUEST has found that in cases which involved the death of a Black person where police force was used:

- Not a single officer was found to have a case to answer - when ethnicity was considered - for misconduct or gross misconduct in respect of racial discrimination between 2015 to 2021.
- There have been no findings of misconduct or gross misconduct for discrimination on the grounds of race against the officers involved.
- No police officer was referred to the Crown Prosecution Service for racially aggravated charging.
- While these cases resulted in no serious sanction against the police on any grounds, the investigatory process has dragged on for as long as six years.

[2] Home Office – Independent Office for Police Conduct (IOPC) Framework Agreement. (July 2018). Available at https://www.policeconduct.gov.uk/who-we-are/accountability-and-performance/our-policies

On paper, England and Wales have a highly developed system of oversight of police conduct, with provision for identifying racism. These nations also have a well-established investigation and coronial system to examine the circumstances of deaths in state custody, for the state to be accountable. However, no death of a Black person following police custody or contact has led to officers being effectively disciplined for racism or held to account.

INQUEST interviewed 12 expert lawyers with experience of cases involving the deaths of Black people following the use of force by the police. The aim was to identify what prevents robust investigation of the role race plays in these deaths and to gather clear ideas about what needs to change and how that might be achieved.

The lawyers reported that the police – at the rank and file level – are often uncooperative when questioned and deny their actions were influenced by racism. Their superiors invariably back their officers. This means no proper investigation can take place by the IOPC, which itself appears to lack courage to force officers to cooperate.

In 2020, the Police's Standards of Professional Behaviour were changed to clarify that failure to cooperate with investigations and inquiries could constitute misconduct. The police watchdog could invoke this "duty of cooperation"[3] to force officers to comply with investigations – but has never done so.

The IOPC has not publicly accepted that institutional racism exists and therefore fails to robustly investigate racism. The IOPC's scrutiny of racism is too often a "tick-box" exercise. It does not look for patterns of actions and conduct in a substantial manner to evidence indirect discrimination, only seeking proof by way of the use of overt discriminatory language.

[3] The Government. (2020). Explanatory Memorandum to the Police (Conduct) Regulations 2020. The National Archives. Available at: https://www.legislation.gov.uk/uksi/2020/4/pdfs/uksiem_20200004_en.pdf

At present, police officers who are investigated by the IOPC can, under the framework for dealing with racism in cases involving deaths of Black people in custody, refuse to answer questions put to them.

Officers are not held accountable and there is no systemic change or learning

However, the lawyers suggested that the guidance from the IOPC for its investigators in such cases, where it can be shown that there is sufficient evidence of unlawful discrimination, should be more explicit to put the onus on the police to offer reasons other than racism to explain their actions.

Significantly the IOPC's guidance on how to determine whether discrimination has taken place, nor the way it is interpreted in practice are in line with provisions in the Equality Act.

If the Equality Act[4] was fully applied in this way by the IOPC the refusal by officers to give a non-discriminatory explanation in cases involving the death of Black people after police contact - offering little beyond "no comment" to the IOPC – should prompt the watchdog to find that there was a case to answer for misconduct on the grounds of race.

If this were to happen, officers who gave no satisfactory explanation would have a case to answer and go to a tribunal. Were the burden of proof to shift to the police, then the IOPC guidance and practice would be legally consistent and on a par with that used in the civil courts. This would represent a step change in what happens at present.

[4] The Government. (2010). Equality Act. The National Archives. Available at: https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

FAMILIES

INQUEST also spoke in depth to six family members of five Black men who died following the use of force by the police. We asked them specifically about consideration of the potential role that racism played in their loved one's death through the investigatory processes. All have been through an investigation, inquest hearing and have a jury conclusion.

The question of whether racism contributed to the treatment of a loved one is invariably in the minds of Black families, but not one most felt they could raise. Their reluctance to raise race with the IOPC and in public statements during the investigation was because they feared being seen to "play the race card" and provoke additional hostility in a process they experienced from the outset as adversarial.

In the aftermath of the deaths, the families experienced the police seeking to deflect from and minimise their possible wrongdoing by demonising their loved ones and drawing on racist stereotypes of Black men that "vilified" them.

Most of the families interviewed felt raising racism with the police watchdog, the media and wider public would be construed as being acrimonious; used against them; and hinder their prospects of unearthing the truth about how their family member died.

According to the IOPC's own guidelines, it is the responsibility of the watchdog to bring discrimination to light. The onus lies with the IOPC to identify possible lines of inquiry – not bereaved families. Families want only for the IOPC to do its job and carry out its duty by explicitly referring to and thoroughly investigating racial discrimination where it is apparent that it may be relevant.

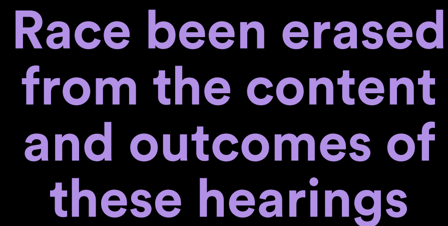
Yet families said that neither the IOPC investigation nor the inquest adequately addressed their questions about why their loved one met with force, not care; why they were treated as a threat rather than in need of help and why force was escalated when their relative was asking for assistance.

Whether racism contributed to the treatment of a loved one is invariably in the minds of Black families

Most families felt that raising racism would be used against them and hinder their prospects of getting the truth

In the absence of direct racist verbal abuse or messages, investigators don't admit race influenced an officer's actions

Families conclude that investigatory processes are designed to protect the police, not to deliver justice



Without these questions substantially answered and no one held accountable, many Black families saw racism as being the only explanation for the police's actions.

One argument INQUEST heard from families was that Black people appear less deserving of care and concern in the eyes of the police. Underlying this point of view is that racism is not merely about words but about the value society places on different groups of people and the fact that Black men, in some cases also with mental ill health, are given very little.

Without fully employing an analytical framework to consider discrimination - despite the watchdog's own guidance - IOPC investigators often are seen to narrow down their inquiry and obscure the context of race within the case. Such an analysis would attempt to draw conclusions about whether an officer has a case to answer on the grounds of racial discrimination from known facts about the statistical link between police use of force and race. This is not how the IOPC makes decisions. Instead, in the absence of direct racist verbal abuse or digital messages, IOPC investigators are either unable or unwilling to admit race as influencing an officer's actions in relation to the use of force.

CORONERS' COURTS

The inquest system is also failing to scrutinise the role that racism might have played in the death of a Black person following contact with the police. The question of race is also almost always absent. It is not in the scope of issues to be considered at the inquest, missing from evidence heard and tested, and therefore not in what a coroner directs a jury to consider and not in narrative conclusions. The result is that recommendations about how to address racial discrimination in policing do not feature in Prevention of Future Death Reports.

Race has therefore been erased from the content and outcomes of these hearings. If an issue has not been explored in an inquest then, by definition, there is no evidence of it and therefore not something on which a jury could conclude. There is no automatic obligation on coroners to consider the role racism might have played in a death. However, if the IOPC were to conclude an officer had a case to answer, it would make it difficult for a coroner not to include the subject in the inquest.

When a coroner does not rest on the IOPC report alone and permits different issues and

new evidence to be heard, an inquest jury can draw different conclusions from the watchdog and highlight the shortcomings in that IOPC investigation.

Our research found inquests are not considering racism because:

- There is an entrenched discomfort among coroners about including race in inquests. Racial discrimination is contested in the public sphere with considerable political pressure not to see it as current problem.
- The lack of sufficient knowledge about discrimination law among most coroners is a current obstacle to race being included in inquests.
- Coroners are unwilling to allow a wider discussion about discrimination in relation to the circumstances of deaths – despite inquests into deaths following police contact falling under Article 2 of the European Convention on Human Rights which look "in what circumstances" the case occurred. Persuading coroners to see racism as part of the "circumstance" in which a Black person died following police contact is currently a hurdle.
- The decision whether to raise race is often far from straightforward, said lawyers. A minority of those interviewed spoke of weighing the potential damage that raising race might have in the minds of the jury.

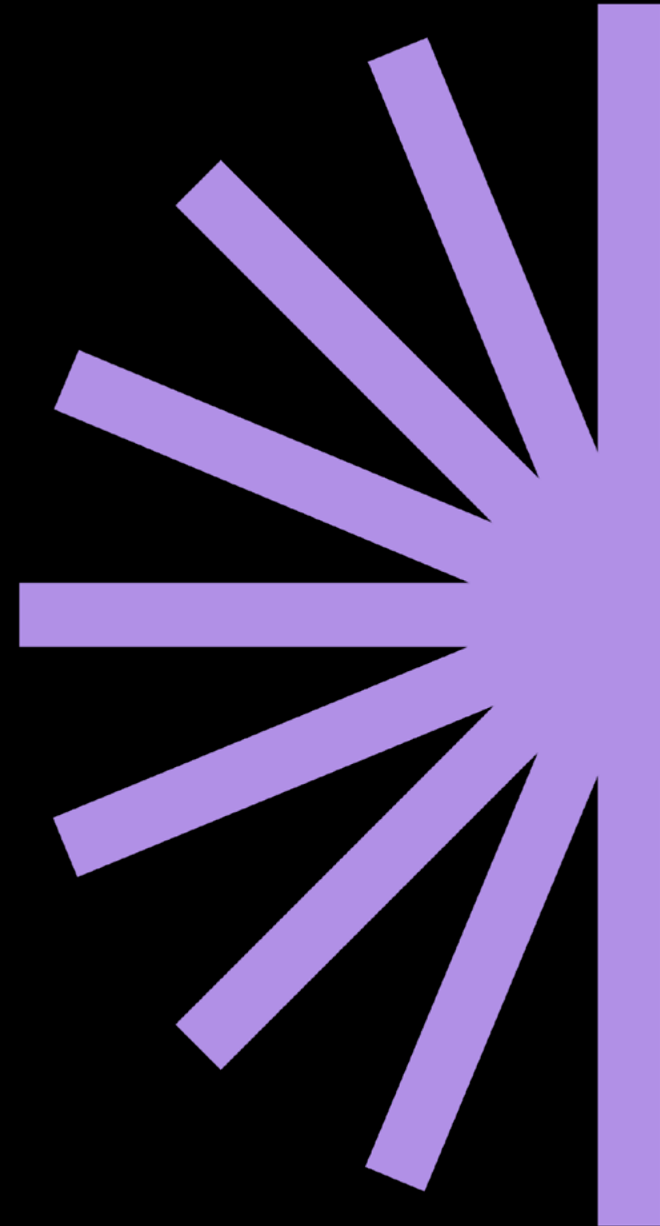
The absence of race in inquests examining police restraint-related deaths of Black men means the process does not fulfil their objective of establishing what happened in such cases. Instead, bereaved families are left feeling that police misdeeds have gone unpunished; that lethal malpractice will continue, and shameful conduct is never publicly acknowledged. Without significant consequences over the years, families conclude that investigatory processes are designed to protect the police, not to deliver justice.

TERMINOLOGY

The term "Black" in the report refers to people of African and African Caribbean background. We include mixed-race African and African-Caribbean people within this group to acknowledge the way they are racialised as Black both within the criminal justice system and wider society.

When examining official data, the report adopted the same racial categorisation "Black" for the analysis. This is because official figures have just one "Mixed" category which does not distinguish between different mixed race groups.

The authorities' racial categorisation is imperfect. INQUEST has worked with families whose relatives have been miscategorised. This has resulted in people who are mixed race categorised as Black and vice versa.



02

Introduction

Introduction

This report seeks to quantify the scale of racial disproportionality in deaths following police contact; highlight Black bereaved families' experience of raising the issue of race; identify what prevents robust investigation of racism and recommend ideas on how to achieve change.

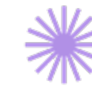
INQUEST's casework shows that investigations into the deaths of people from all communities following police contact do not deliver adequate accountability. But what marks out the issue around deaths of Black people is that despite years of official recommendations and public campaigns the lethal pattern of racial disproportionality continues.

For bereaved families, each new death is a reminder of the state's failure to learn from past mistakes and enact meaningful change. It reveals a refusal to acknowledge and understand the role race plays in these deaths. The recent deaths of Chris Kaba, 24, Oladeji Omishore, 41, and Godrick Osei, 35, only underline just how little learning has taken place.

INQUEST's work shows a long history of cases involving inappropriate use of police force and the stereotyping of Black people as having exceptional strength and size. Equating Black people with 'dangerousness' and criminality has become embedded in police culture and practice. This report focuses on the nations which our casework primarily covers: England and Wales. However, we know the issues resonate across Britain and internationally. This has been highlighted in Scotland where the ongoing Sheku Bayoh public inquiry is uncovering evidence on these very same patterns.

Our research explored recent cases and data, which brings the focus to Black men in particular. However we must acknowledge the Black women have also died in these circumstances, and face similar and specific issues and injustices more broadly.

This report aims to put families' voices at the heart of the analysis. It is only through their tireless campaigns for justice that authorities have been challenged to deal with the unacceptable



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practices of the state. It will also set out to evidence the disproportionality of deaths of Black people following police use of force – despite official denials of the scale of the problem. It examines why accountability processes fail to consider race robustly and the limitations of investigatory methods are explored in depth.

A systemic reticence to properly investigate racism in the most serious of circumstances continues. This is unacceptable. Vital questions need answering about whether or how racial stereotyping and officers' attitudes and assumptions towards Black men informed the way in which they were treated.

Background

In 2020, the visceral image of a police officer kneeling on the neck of George Floyd, a 46-year-old unarmed Black man in Minneapolis, resonated with many of the bereaved families INQUEST has worked with. "I can't breathe," have been the dying words of several Black people restrained by officers in broad day-light on British streets years before George Floyd's reverberated around the world.

Among them are Kevin Clarke, 35, who died after being restrained in London in 2018; Sheku Bayoh, 31, who died after being restrained by Police Scotland officers in Kircaldy in 2015; and Seni Lewis, 23, who died following police restraint in London in 2010.

What happened in Minneapolis was neither new nor a shock to the families of Black people who had died following police contact in the UK. Over the years, high-profile cases of police violence against Black people have provoked riots and disturbances in many British cities. It is only through families' tenacious efforts that the problem of police impunity has been raised at the highest levels of government and with international human rights bodies.

What George Floyd's murder changed however, was the way persistent and pervasive racial injustices burst into sight. It led to a heightened perception of systemic racism among the wider UK public. Police leaders in the UK expressed solidarity with all those who were "appalled and horrified" by the way George Floyd was killed and called for "justice and accountability"[5] to follow.

Missing from the authorities' response was a willingness to acknowledge the UK's own problem of police violence and systemic racism. The very police forces expressing solidarity are among those obfuscating

[5] Police Superintendents' Association. (2020). UK police stand with those appalled by George Floyd death. Police Superintendents' Association. Available at: https://www.policesupers.com/news/uk-police-stand-with-those-appalled-by-george-floyd-death

In the UK there is an ongoing denial by the government and policing authorities of institutional racism

families' search for truth and accountability after the deaths of their loved ones following contact with police officers. Neither did it galvanise political leaders to listen to the protestors' calls to address the lack of justice and accountability nor develop alternatives to policing.

Until June 2021, no police officer at an individual or senior management level had been found guilty of murder or manslaughter following a death in police contact or custody in England and Wales since 1986.

Then PC Benjamin Monk was found guilty of the manslaughter of Dalian Atkinson, a Black man in mental health crisis who was subject to excessive violence from Monk. Following the verdict, Dalian's family explicitly recognised the long-standing lack of accountability for racialised deaths, paying tribute "to all the bereaved families of Black men who have died at the hands of the police and whose fight for justice has not led to successful prosecutions."[6]

[6] INQUEST. (2021). Dalian Atkinson: Police officer sentenced for manslaughter. INQUEST. Available at: https://www.inquest.org.uk/dalian-atkinson-police-officer-sentenced

[7] Home Affairs Select Committee. (2021). Oral evidence: Police conduct and complaints. House of Commons. Available at: https://committees.parliament.uk/oralevidence/1581/pdf/

Murder or manslaughter charges have been brought against police officers in ten other cases since 1990. But in all these cases trials have collapsed or officers have been acquitted by the jury. Before Monk's conviction, in evidence to a Home Affairs select committee inquiry in 2021, the Police Federation had claimed that it was a "massive positive"[7] that police officers had not been convicted of murder or manslaughter.

However, this outcome - in the context of a pattern of deaths that have revealed excessive or dangerous use of force or neglect - in fact shows the inadequacy of the system of accountability to bring prevention and change and the impunity of police officers.

In the UK there is an ongoing denial[8] by the government and policing authorities of institutional racism.[9]

Deaths are treated as isolated incidents with no links made between deaths that would point to racism being structural. The question of racism is a problem the state would rather not discuss; it is neither identified in the investigation process nor in inquests, or other legal processes.

A coroner did, however, look at the role of race in the death of Jimmy Mubenga, a 46-year-old Angolan man who died in 2010 following restraint in his British Airways seat by three G4S security guards during his attempted deportation. Fellow passengers reported they heard him cry

[8] The National Police Chiefs' Council and the College of Policing. (2022). Police Race Action Plan: Improving policing for Black people. National Police Chiefs' Council. Available at: https://cdn.prgloo.com/media/3618aba8b25b4a2494ad20d9b793eb25.pdf

Commission on Race and Ethnic Disparities (31 March 2021). The report of the Commission on Race and Ethnic Disparities. Available: https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities

[9] Defined by the Macpherson Report 1999 as "The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pd

out, "I can't breathe," during the restraint.[10] The coroner, in 2013, highlighted racist material found on the private mobile phones of two of the guards, in Facebook messages posted after Mr Mubenga's death and the "pervasive racism within G4S."

"It seems unlikely that endemic racism would not impact at all on service provision," wrote the coroner, adding that a racist culture "may, self-evidently, result in a lack of empathy and respect for [detainees'] dignity and humanity potentially putting their safety at risk, especially if force is used against them."[11]

This was in the context of private security firms carrying out deportations on behalf of the state, but the observation holds for state enforcement agencies.

Following the unlawful killing inquest conclusion, manslaughter charges were brought against all three G4S officers. However, in their 2014 hearing, an Old Bailey judge refused to allow the jury to hear about dozens of, what he called, "grossly offensive and undoubtedly racist" text messages on the phones of two of the G4S security guards acquitted of killing Mr Mubenga because they did not have "any real relevance"[12] to the trial.

There has been a sea change in how such messages have been viewed. Evidence in the last year from social network posts of racism – as well as homophobia and misogyny – by police officers have caused public outrage and forced authorities to act. Police officers have been investigated, dismissed for gross misconduct[13] and jailed.

[10] BBC. (2014). Jimmy Mubenga: Deportee heard screaming 'I can't breathe'. BBC. Available at: https://www.bbc.co.uk/news/uk-england-london-29998050

[11] Report by the Assistant Deputy Coroner Karon Monaghan QC UNDER THE CORONER'S RULES 1984, Rule 43. (2013) Available at: https://www.42br.com/_files/content/42br-Mubenga.pdf

[12] Booth, R. (2014). Jimmy Mubenga: Judge refused to allow jury to hear about guards' racist texts. The Guardian. Available at: https://www.theguardian.com/uk-news/2014/dec/17/jimmy-mubenga-racist-texts-not-heard-case

Given the weight of evidence, police forces are having to publicly accept that there is a wider systemic issue that has not been dealt with. Baroness Casey's interim review in 2022[14] into the standards of behaviour and internal culture of the Metropolitan police found officers suspected of serious criminal offences have been allowed to escape justice resulting in hundreds of racist, misogynistic and corrupt officers left in the ranks.

Official reviews into the lack of accountability for racism by police

There have been serious attempts to address racial injustice in relation to policing in the last two decades. Key reviews have repeatedly highlighted the failure to properly examine the role racism might have played in deaths of Black people who have died after coming into contact with the police.

The most pertinent to this report is the review, conducted by Dame Elish Angiolini KC, into deaths and serious incidents in police custody. In July 2015 the then home secretary Theresa May announced the Angiolini review and asked INQUEST, as an organisation that has long campaigned on these issues, to have a formal role in ensuring that the voices of families who have lost loved ones in police custody are heard. As a result, INQUEST's executive director Deborah Coles became special advisor to the review.[15]

Prompted by the deaths of Sean Rigg and Seni Lewis - two Black men who died following police restraint - the 2017 Angiolini report[16] recommended that the police watchdog's investigators "should consider if discriminatory attitudes have played a part in

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[13] BBC. (2022). Charing Cross: Met Police vow to 'root out' bad officers. BBC. Available at: https://www.bbc.co.uk/news/uk-england-london-61032343

[14] Metropolitan Police. (February 2022) The Baroness Casey Review. Metropolitan Police. Available at: https://www.met.police.uk/police-forces/metropolitan-police/areas/about-us/about-the-met/bcr/baroness-casey-review/

restraint-related deaths **in all cases** where restraint, ethnicity and mental health play a part (in line with… discrimination guidelines)." (Emphasis INQUEST)

However, only four years before, another landmark review came to similar conclusions. Led by the criminologist Dr Silvia Casale,[17] it also looked at the death of Sean Rigg after an inquest jury exposed serious failings in the investigation by the IOPC's predecessor, the IPCC.[18] Sean had been living with schizophrenia and died, aged 40, at Brixton police station after being restrained by police in August 2008.

The Casale review found there was no evidence that investigators for the IPCC had "explored whether any acts or omissions of any police officers were motivated by the ethnicity of Mr Rigg." The review also pointed out that when police officers had attributed the behaviour of Sean, who was mentally ill, as being normal for "people you come across in Brixton," the watchdog had failed to ask whether the officers had "some reason other than race in mind".[19]

The review concluded that the IPCC should have addressed the issue of race, adding "the lack of reference to race throughout is

[15] Home Office. (2016). Independent review of deaths and serious incidents in police custody. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/503014/Terms_of_Reference__Background.pdf

[16] Angiolini, E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

[17] The Independent Police Complaints Commission. (2013). Report of the independent external review of the IPCC investigation into the death of Sean Rigg. The National Archives. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20131010135155mp_/http:/www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/Review_Report_Sean_Rigg.PDF

[18] INQUEST. (2012). Sean Rigg: INQUEST: Jury Verdict. INQUEST. Available at: http://inquest.gn.apc.org/media/news/sean-rigg-inquest-jury-verdict

[19] The Independent Police Complaints Commission (2013). Report of the independent external review of the IPCC investigation into the death of Sean Rigg. The National Archives. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20131010135155mp_/http:/www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/Review_Report_Sean_Rigg.PDF

not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately."[20]

And in 2006 - seven years before Casale's review - the then Chair of the IPCC, Nick Hardwick, had concluded in his review into the unlawful killing of Christopher Alder, a Black Falklands veteran who choked to death handcuffed and face down in a Hull police station in April 1998 surrounded by police officers joking and chatting, that their treatment of him amounted to "unwitting racism,"[21] as defined in the Macpherson Report.

Hardwick concludes his review with a choice of words that prove significantly prescient given the Black Lives Matter movement had yet to come into being: "The grim conclusion I have reached is not that Mr Alder mattered enough to those who dealt with him on that night…for them to conspire to kill him – but that he did not matter enough for them to do all they could to save him."[22]

The seminal Macpherson Report into the murder of Stephen Lawrence from 1999 stands as the bedrock for each of these later reviews in its finding of institutional racism in policing.[23]

[20] The Independent Police Complaints Commission. (2013). Report of the independent external review of the IPCC investigation into the death of Sean Rigg. The National Archives. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20131010135155mp_/http:/www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/Review_Report_Sean_Rigg.PDF

[21] Independent Police Complaints Commission. (2006). Report, dated 27th February 2006, of the Review into the events leading up to and following the death of Christopher Alder on 1st April 1998. The Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250834/0971_i.pdf

[22] Independent Police Complaints Commission. (2006). Report, dated 27th February 2006, of the Review into the events leading up to and following the death of Christopher Alder on 1st April 1998. The Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/250834/0971_i.pdf

[23] Macpherson, S.W. (1999). The Stephen Lawrence Inquiry. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

The Independent Office for Police Conduct

The IOPC is a non-departmental public body sponsored by the Home Office, which oversees the police complaints system in England and Wales. It is required by law to secure and maintain public confidence in the police. The watchdog says it, "aim[s] to improve public confidence in policing by ensuring the police are accountable for their actions and lessons are learnt."[24]

Police forces are required to refer all cases where contact with officers may have caused or contributed to a death or serious injury. At the start of independent investigations, the IOPC establishes the 'terms of reference' outlining which parts of the incident it will investigate. The watchdog is required to gather evidence to establish the circumstances of the death; liaise with bereaved families and produce a final report.

This sets out the IOPC's assessment of what happened and concludes whether "in their opinion" officers involved have "a case to answer" and should face a disciplinary misconduct meeting or gross misconduct hearing or no case to answer.[25]

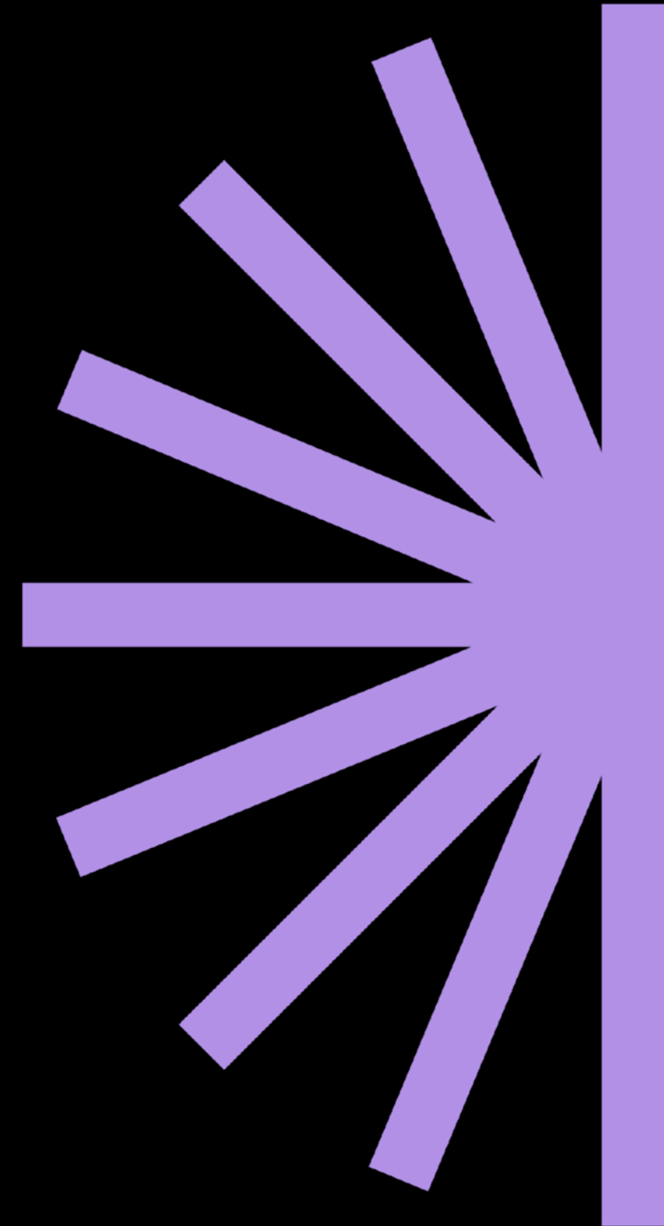
[24] Independent Office for Police Conduct. (2020). Statutory guidance on the police complaints system. Independent Office for Police Conduct. Available at: https://www.policeconduct.gov.uk/sites/default/files/Documents/statutoryguidance/2020_statutory_guidance_english.pdf

The IOPC report is sent to the police force which may disagree with the IOPC's finding and decide not to hold a disciplinary meeting or hearing. In that case, the watchdog can issue a direction to the force to do so.

Importantly, the IOPC's conclusion does not determine whether the police officer or staff member has committed misconduct.[26] It sets out only whether they find that "there is sufficient evidence on which a reasonable tribunal, when properly directed, could find that the conduct of the officer amounts to misconduct or gross misconduct." It is for any subsequent misconduct proceedings to determine whether it is proved and decide on what action will be taken.

The IOPC's findings are also sent to the family of the deceased person and, in those cases where it thinks a police officer or member of staff may have committed a crime, the Crown Prosecution Service (CPS). The CPS decides whether to prosecute. If an inquest is to be held, the coroner will also consider the IOPC report.

[25], [26] Independent Office for Police Conduct. (2018) IOPC independent investigations: Information for police officers, staff and their representatives. Independent Office for Police Conduct. Available at: https://www.policeconduct.gov.uk/sites/default/files/Documents/statutoryguidance/2020_statutory_guidance_english.pdf



03

Evidencing Racial Disproportionality

Evidencing racial disproprtionality

Data on police related deaths

Black men are dying disproportionately following police use of force. Excessive use of restraint is a persistent feature in these deaths.

However, there is still no publicly available ethnic breakdown for all deaths following police restraint – despite it being a key recommendation of the Angiolini report.[27]

This section will show the disproportionality of Black deaths is apparent from both the official data and INQUEST's own monitoring. It will also break new ground by combining previously unpublished datasets to uncover the true extent of restraint related deaths, and the disproportionate number which involve Black people. INQUEST found that:

- Unpublished IOPC data shows that Black people are seven times more likely to die than White people following the use of restraint in and following police custody or contact.
- Official statistics obscure the extent of racial disproportionality.

[27] Angiolini, D.E. (2017).Report of the Independent Review of Deaths and Serious Incidents in Police Custody. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

The IOPC annually publishes data including the 'type of death by ethnicity', which looks at several categories including deaths involving fatal shootings, in or following police custody and 'other deaths following police contact'.

Of concern is that the definition of custody used by the IOPC means that very similar cases where a person was in direct contact with police prior to their death, but had **not officially been arrested or detained, are excluded from the overall 'custody' data, and put in the much broader 'other' category**. INQUEST believes this obscures the overall picture, and makes the annual number of deaths in police custody and contact appear lower than the reality.

When looking at ethnicity, this is particularly important, because it excludes numerous restraint cases from the custody category. These cases disproportionately involve Black people.

One such example is that of former premier league footballer Dalian Atkinson which resulted, in 2021, in the first conviction in 35 years of a police officer for a death while on duty.

The result is that significant cases involving deaths following direct police contact, such as those involving use of force and restraint, are lost in the broad 'other' category. INQUEST

However, Dalian's death – along with numerous other high-profile cases involving Black men - is excluded from the official "death in police custody" data.

Calculating racial disproportionality

Using the two official databases - 'custody' and 'other' - estimates for disproportionately can be calculated. But the Home Office uses only the 'custody' category to count how many deaths occurred by ethnicity and claims that the numbers are "not unusual when looking at long-term trends."[28]

This IOPC 'custody' dataset from 2004/5 to 2020/21 results in Table 1

From this table, Black people are **2.7 times more likely to die than the proportion of the population they represent.**[29] For White people the comparable figure is one, i.e., they die in such circumstances at a rate consistent with their population. This suggests that Black people are more than twice as likely to die as White people.

The broader IOPC category records "deaths that follow contact with the police, either directly or indirectly, that did not involve arrest or detention under the Mental Health Act 1983 and were subject to an independent investigation." This category includes any cases investigated by the IOPC which were not: in custody; road traffic incidents; fatal shootings and apparent suicides following custody. Collating the data over a fifteen year period results in Table 2.

Table 1

Ethnic Group	Number	Deaths %	Population %
White	281	85	86
Asian	10	3	7.5
Black	28	8	3
Mixed	8	2	2
Other	2	0.6	1
Not Known	1	0.3	n/a
Total Fatalities	330	100	n/a

Source: IOPC data showing Deaths in or following police custody by ethnicity 2004/5 -2020/21

Table 2

Ethnic Group	Number	Deaths %	Population %
White	968	83	86
Asian	68	6	7.5
Black	79	6	3
Mixed	14	1	2
Other	19	2	1
Not Known	25	2	n/a
Total Fatalities	1173	100	n/a

Source: IOPC data showing 'other' deaths following police contact by ethnicity 2004/5 – 2020/21

[28] Home Office. (2021). Deaths in police custody: Government Update – 2021. The Department of Health and Social Care and the Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003842/Deaths_in_Police_Custody_-_Government_Update_2021_FINAL_CLEAN.pdf

[29] Assuming constant demographic profiles over the period considered.

According to this data, Black people are **two times more likely** to die than the proportion of the population they represent.[30] For White people the comparable figure is just under one, i.e. they die in such circumstances at a rate consistent with their population. This suggests that Black people are more than twice as likely to die as White people.

INQUEST maintains its own database which goes back to 1990 and is built upon our casework and monitoring of all deaths in or following police custody or contact. A detailed sample of the last decade from these records can also be used to determine whether deaths following police use of force exhibit racial disparities. This data can be seen in Table 3.

Table 3

Ethnic Group	Total	% Total	% Population
White (UK/other)	168	42	86
Black (African/Carribean/UK)	52	13	3
Mixed other ethnic background	8	2	2
Asian (UK/Indian/Chinese/Asian other)	32	8	7.5
Other*	5	1.2	n/a
Ethnicity unknown/not recorded	131	33	n/a
Total deaths excl. road accidents	396	100	n/a

***Other includes Arab, North African, Turkish, Brazilian and other**

Source: INQUEST data analysis 2011-21 of all deaths in or following police custody/contact, excluding road traffic incidents.

[30] Assuming constant demographic profiles over the period considered.

Given the large number of deaths where ethnicity has not been recorded, it would be prudent for these purposes to assume that these are all White people. This gives the most conservative, but statistically safest, estimate.

Using these figures, Black people are roughly **four times more likely** to die than the proportion of the population they represent.[31] White people's deaths are in line with the proportion of the population they represent. Therefore, using INQUEST's database, Black people are around four times more likely than White people to die.

The **IOPC data obscures the full extent of racial disproportionately**, leading to a difference between what the INQUEST monitoring data suggests - that Black people are more than four times as likely to die as White people following police contact or custody - and that implied by the official figures which has the likelihood as half that.

[31] Assuming constant demographic profiles over the period considered.

Custody, restraint and the use of force

In 2017 a review, commissioned by the Home Office,[32] found that the "use of restraint has been found to be more prevalent in cases of Black and Minority Ethnic (BME) individuals who have died in police custody than in deaths of White people. Police use of force has also been found to be greater amongst those with mental health problems."

To examine this disproportionately further, INQUEST sent a series of Freedom of Information requests to the IOPC, and engaged over a number of months with the police watchdog, to look more deeply at the issue of race and categorisation. This process further confirmed how significant deaths which led to serious public concern about police use of force and in some cases, **highly critical inquests, are excluded from the data set used by the government due to the way in which the data is categorised**.

For example, in the year 2017/18 the IOPC counted 23 deaths in or following police custody. Of these, 10 deaths occurred following the use of police restraint (one of which also involved a Taser). Six of those restrained were White. Four were Black. These include the cases of Nuno Cardoso, Kevin Clarke and Darren Cumberbatch.

In the same year, the IOPC counted 171 "other deaths following police contact." Of these, six deaths followed the use of police restraint. Three were White and three were Black men. This includes the high-profile cases of Edir 'Edson' Da Costa, Rashan Charles, Shane Bryant – who were all Black; and Douglas Oak and Marc Cole – who were White.

From this year alone it is clear that **restraint-related deaths are split between the two categories, shrouding the full picture.**

[32] Home Office. (2017). Deaths in police custody: A review of the international evidence. The Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655202/deaths-in-police-custody-review-international-evidence-horr95.pdf

The government uses the "custody" data when referring to deaths and race in response to the Angiolini report's recommendations. It ignores the broader "other" category, which also includes the deaths of Black people involving the use of force following police contact. This allowed, in 2021, the Home Office to claim that the data "does not suggest that ethnicity impacts the likelihood of dying during or following police custody." The government says arrest and detention rates account for the apparent "racial disparities."[33]

The Home Office goes on to claim that the "data also does not suggest that black men are more likely to die in custody in cases where use of force or restraint is present."[34] Official bodies do not publish the detailed data to back up this assertion.

In 2020 the Commission on Race and Ethnic Disparities said that a disproportionate number of ethnic minority people have died following use of police force. Its report stated "in the 11 years to March 2009, 87 people died following police restraint. 67% were White, 16% were Black, 7% had Mixed ethnicity, 6% were Asian, and the ethnicity was not known for 5%. However, this does not mean there is a causal link between the use of restraint and death, restraint is typically seen as a contributing factor as opposed to a cause in its own right."[35]

[33] Home Office. (2021). Deaths in police custody: Government Update – 2021. The Department of Health and Social Care, the Home Office and the Ministry of Justice. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003842/Deaths_in_Police_Custody_-_Government_Update_2021_FINAL_CLEAN.pdf

[34] Home Office. (2021). Deaths in police custody: Government Update – 2021. The Department of Health and Social Care, the Home Office and the Ministry of Justice. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003842/Deaths_in_Police_Custody_-_Government_Update_2021_FINAL_CLEAN.pdf

[35] Commission on Race and Ethnic Disparities. (2021). Commission on Race and Ethnic Disparities: The Report. Commission on Race and Ethnic Disparities. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf

The most recent relationship between race and the use of restraint can be drawn out from the data that INQUEST obtained. From 2012/13 to 2020/21, there have been 119 deaths involving restraint recorded by the IOPC "in or following police custody" or recorded as "other deaths following police contact." Of these 23 were of Black people, 86 were White, 5 were Asian and 4 were mixed race.

Assuming constant demographic profiles over the period considered, Black people are 6.4 times more likely to die than the proportion of the population they represent. For white people the comparable figure is just 0.84.

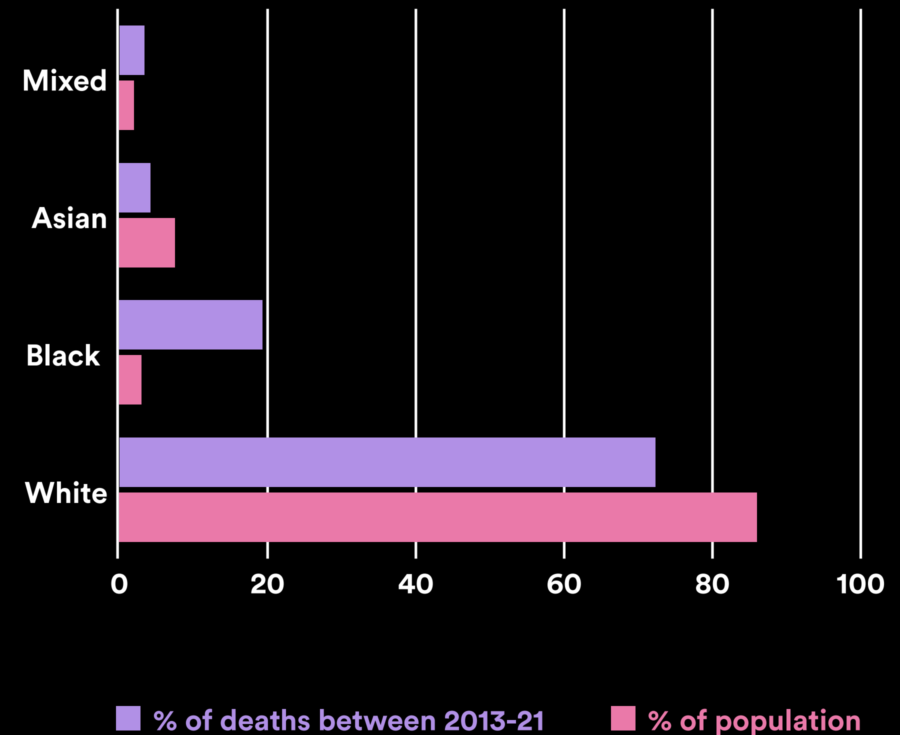
Using these figures, Black people are seven times more likely to die than White people when restraint was involved. **This is a much higher racial disproportionality than that derived from the government's preferred "custody" dataset**.

The chart (Figure 1) opposite shows just how much bigger the proportion of deaths of Black people involving restraint is compared to their make up of the population.

The IOPC argues that these figures ought to be treated with some caution, particularly given the numbers of deaths are relatively low and says the data does not provide a definitive picture of racial disproportionality. The watchdog also indicated that the circumstances vary in these cases. It says that even if one were to look at arrests alone, there is no data that gives a "demographic breakdown" of those arrested or detained to use as a comparison.

While INQUEST accepts there might be caveats in any analysis of the data, the findings in this section clearly evidence the existence of racial disproportionality. It is also clear that the true picture of the extent of the disproportionality is obscured in official figures. Given that the data on ethnicity and police deaths is being collected, it should be used to inform effective policy making.

Figure 1: Deaths in or following custody and those following police contact that involved restraint by ethnicity [IOPC]



Source: IOPC data from 2012/13 to 2020/21 on restraint and race

Evidencing the IOPC and inquests' failure to challenge racism

1. Police watchdog

Despite the racial disproportionality in relation to deaths involving police use of force, INQUEST's own monitoring shows that police officers involved in these cases do not face disciplinary or criminal proceedings for racial discrimination.

To examine the watchdog's track record when investigating the role of race in such deaths, INQUEST submitted freedom of information requests to the IOPC, which were returned in October 2021. We asked the IOPC about the outcomes of investigations into deaths of Black people involving use of force which considered the issue of race in the terms of reference.

IOPC outcomes include decisions about whether a police officer has a case to answer for misconduct or gross misconduct following its investigation; whether to refer an officer to the CPS where there is an indication they may have committed a crime and the results of any subsequent misconduct or criminal proceedings.

The responses INQUEST received show that in the six years from 2015/2016 to 2020/21 there were seven investigations into a "death during or following police contact involving police use of force and a term of reference relating to ethnicity as a potential contributory factor in the police treatment of the deceased." This number includes only those cases where ethnicity was in the terms of reference. It is not the total number of police-related deaths where race could have been considered a factor.

The bar is set low for the IOPC when making decisions in these cases. It does not have to determine whether an officer is at fault, only whether there is a case to answer based on whether a tribunal "could" find the officer's conduct amounted to misconduct or gross misconduct.

It is for the relevant police force to then carry out any disciplinary action. They can hold disciplinary hearings (for gross misconduct) or meetings (for misconduct).

- The police watchdog in each of the seven investigations considered found no case to answer for misconduct or gross misconduct in respect to race or ethnic discrimination.
- Only in one case in the six years did the IOPC "recommend" that an officer "be reminded of the standards of professional behaviour, in particular equality and diversity which requires officers to act with fairness and impartiality as not to discriminate."
- There were no findings of misconduct or gross misconduct for racism against the officers involved and no police officer was referred to the Crown Prosecution Service.
- Of these seven IOPC investigations, only two were closed and neither resulted in a decision that there was a case to answer for racial discrimination or a breach of professional standards regarding ethnicity or race. Of the rest three remain open, one was re-opened, and another was completed but remained open while an inquest was pending.

A self-commissioned report said the IOPC has made progress in reducing the time investigations took. According to the 2022 Strategic Review of Policing chaired by Sir Michael Barber, the average length of investigation under the IOPC's former incarnation was 12 months, whereas under the new system, the majority were over in eight months.[36]

However, INQUEST's FOIs reveal a rather different picture. They show that **investigations into deaths of Black people involving**

[36] Strategic Review of Policing in England and Wales. (2022). A new mode of protection: Redesigning policing and public safety for the 21st century. Strategic Review of Policing in England and Wales. Available at: https://www.policingreview.org.uk/wp-content/uploads/srpew_final_report.pdf

use of force are taking years. One case in 2015/2016 remained open almost six years later.

This is more evidence that Black families bereaved due to police-related deaths are **failed by a system which does not meet their needs** or give them the timely justice they deserve.

Our research also found that even in some of the most high-profile police-related deaths of Black people in the last five years, the role of race was not included in the IOPC investigations terms of reference. **This means that vital questions about race are not being asked**.

INQUEST also looked at a sample of watchdog reports into the deaths from 2008 to 2019 of 12 Black men following restraint by the police, including ten reports released since the Casale review. That sample reveals that the IOPC, and indeed its predecessor the IPCC, are **perpetuating the failures identified in Casale and Angiolini by not giving due consideration to the role that racism might play in deaths involving police contact**.

For example:

- Four of these reports contained **no mention** of race, racism, ethnicity or discrimination in the investigation's terms of reference – two of these were released in the last five years. INQUEST heard an example of a death which occurred in 2021, where race was only included in the terms of reference at the family's insistence.

- Even when race is included in the terms of reference, IOPC investigators all too often simply **take at face value the officers' denial that race played a part** in their actions or decisions. In one report from 2018, an officer's denials are referred to by the watchdog's investigator as "evidence" that no discrimination took place.

- In a report from 2015, the IOPC's predecessor, the IPCC, referenced wider expert and empirical research that evidenced Black men are often stereotyped as criminal and violent. Officers did not answer questions in the investigation interviews about whether the deceased man's race had any bearing on their actions. The watchdog however emphasises the importance of recognising that the absence of an account from the officers does not prevent a finding of case to answer for discrimination. The IPCC expressed concern that many features of the case closely mirrored others highlighted by the report of the Adebowale Commission into policing and mental health commissioned by the Metropolitan Police, which found that "stereotyping of agitation and disorientation as violence appeared in the cases as particularly pronounced," with Black men. Yet the watchdog concluded it "could not find enough evidence" and that officers had no case to answer for discrimination. The report said that the use of force and level of restraint involved in this case may have been down to racism or ignorance or a lack of training. But that it was "not possible to distinguish sufficiently between these factors to find enough evidence that the use of force and restraint was motivated by discrimination on the grounds of race."

- It is also clear that police officers themselves are **unwilling to explore whether race might have influenced them**. They usually give "no comment" replies when questioned on the matter. In an IOPC report from 2019 concerning the death of a Black man who had told police, "I can't breathe" while they restrained him, an officer involved described the question about whether ethnicity played any part in their actions and decisions as, "a ridiculous notion."

What our sample shows is that there has been no real progress in the watchdog's acceptance of institutional racism, identified in the Macpherson report, in explaining police behaviour towards racialised communities.

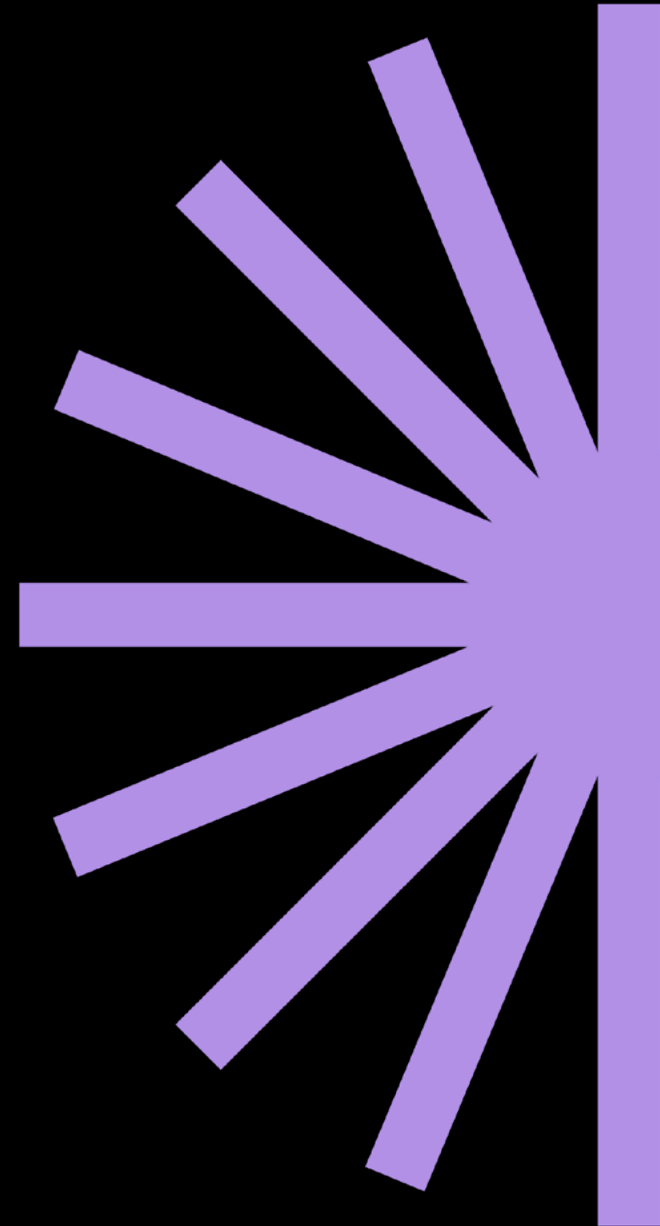
2. Coroners' courts

INQUEST looked at the extent to which race and racism was examined in the inquests of 12 high profile cases of police restraint-related deaths of Black men that occurred between 2008 to 2018. In each case, we looked at the Record of Inquest (ROI), which sets out the findings and conclusion of the hearing and, where relevant, the Prevention of Future Deaths Report (PFD), which sets out preventative actions if the coroner considers there is a risk of other deaths occurring in similar circumstances.

We found **not a single record or report mentioned racial discrimination or racism**.
In fact, in only two of the ROIs and one PFD is the ethnicity of the Black men who have died stated at all - only for it to never be referred to again. The result is the possible role race might have had is entirely absent from the official version of these deaths. Moreover, it is often at odds with how their bereaved family and, increasingly, the wider public understand the context of the death.

04

Family Voice



Family Voice

The Experience of Black Families: Raising Race in Investigations and Inquests

The state has a legal responsibility to answer questions about the circumstances of a person's death in its custody. Yet the families of Black people who have died following police contact say that their concerns about racism are not addressed. The issue of race is absent from the official narrative of what happened to their loved one. The result is a gulf between the way the state characterises the events surrounding these deaths and how they are often understood by families themselves.

Despite their concerns about the role race played, most families said they **had not felt able to voice them in the investigatory process**. Why is it so difficult for Black families to raise this issue and why are they left so disillusioned that they would ever get the authorities to admit that race matters?

To answer these questions INQUEST spoke in depth to six family members of five Black men who died following the use of force by the police. INQUEST worked with the families to establish the facts about the death of their loved one. This included engaging lawyers to represent them during the investigation and inquest and other legal processes.

These interviews focus on their struggle to try and achieve justice and accountability. Families have been forced to campaign because the systems of investigation and accountability have failed. They have become powerful advocates for change.

We asked them specifically about the examination of the role of racial discrimination in their loved one's death through the investigatory processes. All have direct experience of the legal processes following deaths and have been through investigations and an inquest hearing before a jury. All, bar one, have a police watchdog final report into the death of their loved one. In every case, families have experienced many years of delays.

While the circumstances of their loved ones' deaths and the defects in the way they were investigated have been sufficiently serious to bring about changes in the law and police guidance; brought far-reaching recommendations from external reviews; and returned highly critical inquest conclusions on the "unlawful", "excessive" or "disproportionate" force used, not one has resulted in a conviction of, or upheld a finding of gross misconduct against, a police officer. The police have kept their jobs and, in some cases, been promoted.

This report is directly informed by families' experiences and this section will give a voice to some of these families, presenting their experience in their own words.

Key themes

1 Families want race to be thoroughly investigated

INQUEST's research found that although the question of the role racism played in a death is discussed privately, Black families are reluctant to raise the issue initially. They want to know the truth about what happened to their loved one, for action to be taken to prevent similar deaths and for those responsible to be held to account. **But the question of whether racism contributed to their treatment and death is invariably in the forefront of Black families' minds**. This stems not merely from the knowledge of the police's actions in their own case, but also from an awareness of the persistence of racial disparities in the policing of Britain's Black communities and previous deaths of Black people in custody.

Families reported that they started out, in the aftermath of the death, hoping the investigatory process will be fair, honest, transparent and conducted with integrity. They wanted accountability and wanted to cooperate with the investigatory process to get to the truth. Some families also said they entered the process trusting that the IOPC and subsequent inquest would make the "obvious" question of race part of the investigations.

In that context, although families thought race played a part in the death, they often didn't raise the issue themselves with the police watchdog. However, by the end of the process all the families interviewed by INQUEST concluded that race had played a part and that the IOPC and the coronial system **should have thoroughly investigated whether their loved ones' race had influenced the actions of the officers**.

The families viewed racism as having played a part in the death once details of the incident began to emerge.

They saw **a disproportionate level of violence and excessive response** to the behaviour of their family member. Learning of the way police responded to their loved one's mental health crisis with force that included prolonged and repeated use of prone restraint and in some cases baton strikes and Tasering led them to conclude their fathers, sons and brothers were dehumanised and racially stereotyped in the eyes of the police as 'big, Black and dangerous'.

The way the police – and in some cases the health service - neglected to respond or treat their relatives' condition as a medical emergency when they struggled to breathe or became unconscious was profoundly shocking to the families. It suggested that their loved one's life had little value in the minds of the police or the emergency services. Officers, in several cases, spoke of the men as "faking" the gravity of their state as they lay dying. "He was a piece of shit to them," one family member said.

2 Dealing with demonisation and low social value

To differing degrees, families reported having to **defend not only their loved one, but themselves against racialised stereotypes from the outset**. Several described how they faced negative media reporting and inaccurate police statements that started in the immediate hours after the death.

Families told INQUEST they encountered a pattern of defensiveness by officers that focused on condemning the person who had died. In their view the IOPC and inquests **inadequately challenge** the police's version of events. The upshot is that families are often left with conclusions that, they say, effectively blame their loved ones for their own deaths.

The 2017 Angiolini report found that many families thought that the then watchdog, The Independent Police Complaints Commission, "does not always feel truly independent of the police or of police culture."[37] Seven years on, the families interviewed in this research believe that this remains the case.

Some of the families compared – and contrasted - their protracted, and ultimately unsuccessful, journey to try and bring accountability with the five-year battle by the family of former professional footballer, Dalian Atkinson, which culminated in 2021 in a British police officer becoming the first in more than three decades to be convicted of manslaughter while on duty.

For families, the conviction was both a source of hope, a sign that police officers could be held criminally accountable, and despair because they had not been able to obtain any measure of accountability for the death of their own loved ones. They rationalised it in the interviews as an anomaly. Atkinson's celebrity status meant he could not, like their own relatives, be so easily dismissed and vilified by the authorities.

Some reflected too that the IOPC and CPS investigation into last year's murder of Sarah Everard by serving Metropolitan Police officer Wayne Couzens was rightly robust and his conviction, fitting and swift. They saw the case as stark proof that the state is highly capable of responding rigorously to a police-related death, albeit one in very different circumstances, when the life taken is seen to have high social value in the court of public opinion.

Families spoke of their anger and frustration by what they saw as the watchdog's failure to interview officers and gather crucial evidence immediately or at an early stage after the death – as the police would have done when gathering evidence if a civilian was involved with someone's death. It was extremely damaging for the confidence in the investigations of several of the families interviewed to find out that crucial police video footage of the incident went inexplicably missing. In one case officers involved were not kept apart before giving their statements.

Families perceive an inconsistency in the quality of investigations as directly related to a hierarchy where being Black and in a mental health crisis places their loved ones lower down the social scale. They said they have no reason to trust that the IOPC will hold officers to account for racism, because **they know there has been no such outcome in previous deaths**.

3 The Hazards of Raising Race

Families said the police aimed to extend what they saw as a tactic of **racist demonisation and reputational damage** to the wider family, describing, in some cases, how police officers approached them as if they were suspects, instead of treating them with sympathy.

The police visit in the aftermath of the death struck some families as an assessment of whether the force could spin racist narratives about them as associated with gangs or drugs rather than express condolence. In one case, the police watchdog reiterated misinformation by the police that wrongly claimed their loved one was committing a crime when he died - and continued to do so even after the family made clear it was false and asked it to stop.

[37] Angiolini, D.E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

In the face of such treatment, some families said they made a **deliberate decision not to speak publicly** about their concern that the police's actions had been influenced by their loved ones' race, believing that to do so would jeopardise their chances of getting justice. They explained this form of self-censorship as a necessary safeguard against the denigration that, in their experience, inevitably follows when racism is raised as a matter of concern.

The Black families that spoke to INQUEST were all aware of the negative attitudes towards naming racism that currently circulate in wider British society. They said they considered raising race during the investigatory processes hazardous.

Families said they were reluctant to raise race with the IOPC and in public statements during the investigation because they feared being seen to "play the race card" and provoke additional hostility in a process they experienced from the outset as adversarial. Raising the issue of race, families said, could elicit accusations of "having a chip on your shoulder"; being "militant," "predictable"; "an angry Black family" or "a typical Black family."

They said doing so risked making the process of police accountability even more acrimonious. They feared that the issue of race might be used against them and hinder their prospects of unearthing the truth about how their family member died. Instead, families explained that deciding not to talk about race was a necessary strategy to "play nice" and keep watchdog investigators on their side.

They also felt that speaking out would meet with denial by the police. Most of the families interviewed felt it imperative to keep their concerns about racism under wraps, fearful of unleashing such a backlash while the investigation was ongoing, and where the stakes in getting justice were already so high.

Families, in some cases, spoke about the double trauma of being bereaved then having unproven and prejudicial police narratives amplified and circulated on social media and in the press.

4 The legacy of failing to investigate racism

Bereaved families say the system of accountability is anything but. Instead, they view it as a way for the state to **deny responsibility and close ranks** to protect their officers from scrutiny. Families said neither the IOPC investigation nor the inquest answered the question of whether racist assumptions and prejudices influenced the police's actions.

When asked what they wanted to see change, families said they wanted the onus to be on the IOPC, the coroner and the Crown Prosecution Service to **automatically include race in any investigation**. And for lawyers to raise it automatically on their behalf.

While some families credit the inquest into the death of their loved one with unearthing new facts; bringing new evidence to light or revealing inconsistencies in the police version of events, **all said it failed to establish whether racism was a factor**. The issue was not in scope of what the coroner directed the jury to consider in any of the cases. This struck some families as particularly shocking given that they heard their loved one described in racialised terms by police officers during the inquest including having extraordinary size and strength to justify the use of prolonged restraint.

Without race being properly considered by the IOPC and in inquests examining police use of force in deaths of Black men, the watchdog and coronial system fails to fulfil its purpose of ensuring the full facts are uncovered and addressed.

The impact on families cannot be underestimated; mental and physical ill health; divorce and mental breakdowns are part of the fallout. They suffer a sense of disillusionment with wider society and its institutions.

When accountability never comes, and people continue to die in comparable circumstances, **the trauma never ends**.

Sean Rigg

Sean Rigg, a 40-year-old musician and music producer, died on 21 August 2008 after four Metropolitan Police officers handcuffed and restrained him in the prone position and leant on him for at least seven minutes in Weir Estate in Balham.

Sean had missed taking medication for schizophrenia and was experiencing a mental health crisis, behaving erratically and aiming karate kicks at members of the public. He was otherwise physically fit and healthy. Earlier the same day, staff at the hostel he was staying in called the police for help, but the police failed to respond. The police later claimed that they failed to match the 999 calls from when Sean was behaving erratically in the street to the earlier calls from the hostel that named Sean. This would have made it possible to quickly identify his history of mental illness.

Sean was arrested for assaulting a police officer, public disorder and the false allegation of stealing a passport that was actually his own. He was taken the short distance to Brixton Police Station placed in a V shape position – face down with his legs bent behind him - in the foot well of the caged rear section of the police van where he was left for 10 minutes unattended and unmonitored despite no longer being fully conscious. At 20.03, officers "walked" Sean to the caged area at the back of the station and left him collapsed and unresponsive on the floor for 35 minutes when his heart and breathing were found to have stopped. He was formally pronounced dead in hospital after transfer by ambulance, but the inquest jury concluded that Sean had died, following cardiac arrest, at 20.24 at Brixton Police Station.

The initial IPCC investigation from 2008 to 2011 into Sean's death concluded that there was no evidence of neglect or wrongdoing and that the police had acted "reasonably and proportionately."

The inquest, held in June and July 2012, highlighted serious shortcomings and failings in the IPCC's investigation. The jury concluded on 1 August 2012 that the police had used "unsuitable and unnecessary force" on Sean; that officers failed to uphold his basic rights and that the failings of the police "more than minimally" contributed to his death. The jury also found the NHS was culpable. The South London and Maudsley NHS Foundation Trust (SLAM) was criticised for failing to organise a mental health assessment for Sean; failing to ensure that he took his medication and for missing signs that his mental health was deteriorating.

The Coroner in November 2012 issued a highly critical Prevention of Future Deaths report (known at the time as Rule 43) which identified critical learning for the mental health care and police services involved. These included establishing joint protocols between SLAM and the Metropolitan Police Service (MPS) for meeting the needs of those presenting with urgent psychiatric problems which require interagency cooperation. It also addressed apparent weaknesses in the way the MPS handles those with mental illness in custody. "…the lack of dynamic risk assessment of Mr Rigg when he began bizarre behaviour in the van, in particular not to assess whether he was all right, was of great concern and not explained," the coroner wrote.

Establishing whether any acts or omissions of any police officers were motivated by Sean's ethnicity was in the IPCC's original investigation terms of reference – only for it to be never mentioned again and entirely absent from the conclusions. Indeed, the IPCC's subsequent own internal review emphasised that it had found no evidence that the officers were questioned on the issue.

In addition, IPCC investigators waited up to eight months to interview the police officers who came into contact with Sean the night he died, and nine months before speaking to the 999 call handlers. Investigators also failed to seal off the area where he was arrested before being taken to the station.

Following the critical inquest outcome that clearly rejected the IPCC investigation conclusions, the IPCC commissioned an independent external review of its investigation into Sean's death, the first ever into an IPCC investigation. Led by the criminologist and former president of both the European and UN committees for the prevention of torture and inhuman and degrading treatment, Dr Silvia Casale, the review criticised the IPCC for accepting accounts from officers that were "improbable" and "implausible." Officers were allowed to confer with each other before making initial statements to investigators.

The IPCC said it could no longer stand by its original findings, accepted the review in full, and reopened its investigation to consider misconduct charges.

The Metropolitan Police requested that the IPCC investigate the "honesty and integrity" of the evidence given to both the IPCC and the inquest by one of the officers. In April 2014 the IPCC asked the CPS to consider whether charges of perjury and perverting the course of justice should be brought against two of the officers. One had given evidence at the inquest that he had checked on Sean and carried out a risk assessment while he was detained in the police van, including his posture and his general demeanour, but CCTV evidence proved he had not visited the van at any time. The other officer had corroborated his version of events.

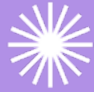
The CPS said in 2015 no criminal charges would be brought over Sean's death, bar the count of perjury against one officer.

He was found not guilty by a jury following a full trial in November 2016.

In 2018 the IOPC directed the Metropolitan police to bring gross misconduct charges against five officers involved in the death. All were accused of failing in their responsibility to ensure Sean's safety; four of them of lying to investigators and an inquest jury to hide the truth; and three of them of excessive force.

In March 2019, after six weeks of hearings, the misconduct panel dismissed all the charges on the grounds that "none of the allegations are proved." The disciplinary panel's findings included the observation that "restraint in the prone position for 7 minutes would not in itself necessarily be regarded as being for an excessive time".

Sean's case and the years of campaigning by his family were central to sparking and informing the Independent Review of Deaths and Serious Incidents in Police Custody by Dame Elish Angiolini, published in October 2017. Ordered by Theresa May while she was Home Secretary, the report contains 110 recommendations for overhauling the way in which the police and health authorities deal with people with mental illness and how the police watchdog investigates deaths. Many of these have yet to be implemented. However, the family's campaigning did significantly speed up the installation of cameras in the back of police vans in the London area. It has also led to greater public awareness of issues around race, mental health and policing.



Marcia Rigg speaking to INQUEST

When Sean's sister, Marcia, first learned of his death, the question of police racism was not one the family focused on. "We just wanted to know what happened," she says. "Ironically, I was not aware of deaths in custody at all. I was aware of police brutality and the issues of racism but, until Sean died, I didn't realise there was a list of ongoing deaths."

When the family typed in 'deaths in police custody' and found other cases had similarities to the way Sean died, Marcia was shocked. She was working as a legal secretary at the time. One of the lawyers she worked with, hearing about Sean's death, asked her if she knew about Christopher Alder, a Falklands veteran who died while handcuffed on the floor of a Hull Police station in 1998, while officers laughed and speculated he was faking illness. "I said 'no', and he tapped Christopher's name in and when I went around to his desk and looked at it, I couldn't believe it. I met his sister, Janet. We met the family of Roger Sylvester [who died after being restrained for 20 minutes following a mental health crisis]. So the issue of race was racing through my head because the deaths were so horrific and the cases were almost identical in many aspects. So we knew the issue of race was a big issue."

But the family made a conscious decision not to speak of it publicly. The reasons were twofold: first, Marcia says, Sean above all else was human, and investigating the police's abuse of his human rights was paramount. "Because other people were dying in custody - White people - and so race shouldn't matter," she says. "These people are human beings whether they're Black or White, and that was the whole journey right through to this point almost 15 years later."

Second, the family were all too aware of the denial and hostility raising the issue of race can bring. "If I made a statement or was on the news, I consciously wouldn't pull the race card. Never. Because of the public perception, the ordinary Joe Bloggs reading the paper might think: 'Oh you lot, you always say that. You've got a chip on your shoulder'. I'm not going to give them the opportunity to say that to me. We know, but the police will never admit it, so it's pointless saying it," Marcia says.

The decision not to raise race with the IPCC was also to prevent the stereotypes often levelled against Black people when they call out racism. The family were reliant on the watchdog to uncover how Sean died and did not want racist stereotypes to impact on their relationship with the IPCC when the stakes were so high. "I was looking at it from a legal perspective. Okay, the issue of race is there. Maybe the solicitor can bring it up. But strategically I'm not going to pinpoint that as the focus, because it's not going to be beneficial to me. We didn't want to say - in order not to be acrimonious to them. They could say, 'This is a typical Black family, they're aggressive, they come in here kicking off'. So we didn't do any of that."

> **"We know, but the police will never admit it, so it's pointless saying it**

Marcia also thought, in the aftermath of Sean's death, that the IPCC investigation would unearth the facts about how Sean died; the truth would

surface about the police's role in his death – and only then would she talk about race. "All we wanted was the evidence and nothing but the evidence.

in a timely manner. They didn't cordon off the area. There were lots of questions and we were just flabbergasted that they weren't doing basic things."

“ It's deliberate. They deliberately do not question the police officers straight away, because the police are getting their stories straight.

The strategy was, once we had gathered the evidence and the facts we'd say, 'He died because they restrained him to death. By the way, he's Black. They do it mostly to Black people. That's where the issue of race comes in'."

But the evidence was not forthcoming. "We couldn't understand why the IPCC weren't investigating it. They hadn't interviewed the officers

With no officer held accountable for Sean's death almost 15 years later, despite the damning inquest conclusion and the family's prolonged legal battles, Marcia says she sees the lack of robust investigating by the IPCC in Sean's case as part of a pattern. "Years down the line, you understand their way of investigating. I noticed the systemic patterns in other cases. It's not that they're not doing a proper investigation.

It's deliberate. They deliberately do not question the police officers straight away, because the police are getting their stories straight in that time. It's an immediate cover-up from the very night. They delay giving you the documentation so you can't piece it together. They knew what they were doing."

What's also changed since Sean died is that Marcia is, "absolutely, categorically certain" now of the role racism plays in deaths of Black men following police use of force, having learned of previous and subsequent restraint-related deaths. She supports other bereaved families and has attended many inquests of their loved ones. "I hear the officers on the witness stand and the pattern is that they're [the police] scared of them. 'He was so strong, we were sweating'; 'He was resisting'. It's nonsense. We're not stronger than anybody else. We're not madder than anybody else. White people, when they're psychotic or they're scared, find strength. If you're going to die, you're going to try and save your life, right? You find all the strength you can. We're just trying to breathe, because somebody is on your neck."

Marcia says the question of whether racism played a part in the deaths of Black people following police contact must be thoroughly considered. "It has to be asked. 100%. It should be standard. Cut and dry. A Black man dies in custody: the issue of race needs to come into the investigation. Full stop."

Marcia doesn't believe the police will ever acknowledge it, however. "They will never admit it. They're not going to admit it. No, they will not. Because it's embarrassing for them. The British establishment does not like embarrassment. They'd rather lie."

Marcia stuck to her strategy. Last Autumn she addressed the UN Human Rights Council about police violence and systemic racism. "I'm talking about race now. Because I was always going to. At the end."

Seni Lewis

Seni Lewis, a 23-year-old IT graduate, died in 2010 after he was held forcefully on the floor for more than 45 minutes in successive episodes of prolonged restraint by 11 Metropolitan Police officers. He had no history of violence or mental illness and had gone to Bethlem Royal hospital in south-east London voluntarily with his parents after an episode of mental ill-health that began over the August bank holiday weekend.

He attended Bethlem Royal Hospital as a voluntary patient, but when he tried to leave, he was detained under the Mental Health Act and staff called the police for assistance.

Police placed Seni in handcuffs and moved him down to a seclusion room in the hospital where he was subjected to prolonged restraint while shackled in two sets of leg restraints and two sets of handcuffs. He lost consciousness whilst under restraint and was pronounced dead four days later.

The inquest jury in 2017 found that Seni died as a result of the prolonged restraint which amounted to the use of excessive, disproportionate and unreasonable force by the police. While acknowledging that race was "the elephant in the room," the coroner declined to allow the officers to be questioned about the role racial discrimination might have played in Seni's death and it was not among the questions the jury were asked to consider.

The conclusion was also critical of failings within Bethlem Royal Hospital, (part of the South London and Maudsley Mental Health Trust) as well as the failure on the part of the hospital staff and the police officers to provide basic life support when Seni collapsed under restraint.

The initial investigation by the IPCC into the death was conducted without any questioning of the officers on the premise that even the possibility of criminal or disciplinary proceedings could be excluded from the outset. Following a challenge by the family in the High Court in August 2013, the IPCC was compelled to admit that the investigation had been inadequate and ineffective, with the result that they were required to undertake a fresh investigation.

The re-investigation took a further 20 months, concluding four and a half years after Seni's death. The case and 2015 IPCC report were then re-referred to the CPS.

The re-investigation report did consider whether Seni's ethnicity had any bearing on the actions of the officers involved in his restraint but concluded the matter was "not possible to distinguish sufficiently."

The IPCC referred the 2015 report to the CPS because it was of the view that the evidence outlined in the report may, in the circumstances, indicate offences of assault, misconduct in public office and manslaughter. The CPS decided in May 2015 that there was "insufficient evidence" for a realistic prospect of a conviction against any of the police officers involved in Seni's restraint for any offence.

In a statement about its decision, the CPS said, "the bulk of the evidence has remained unaltered from that which was referred to us in 2012." It also said that when the officers were interviewed by the IPCC they invoked their right to silence (the right of every suspect) and did not answer questions, relying on prepared statements."

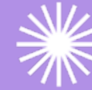
The IPCC concluded six officers had a case to answer for gross misconduct for their involvement in the prolonged restraint of Seni.

The Prevention of Future Death Report, issued by the coroner in June 2017, raised concerns about the police's awareness of the dangers of prolonged restraint and their training around restraint techniques. Also of concern was a lack of training and understanding between healthcare and police staff about their roles and responsibilities.

In October 2017, a police misconduct panel, with press and public excluded, dismissed the gross misconduct charges against the six officers. The hearing concluded that the failings were outside the remit of the panel and were a "matter of performance."

Seni's case and the years his family fought for accountability were key to launching and informing the 2017 Angiolini Review.

Following years of campaigning by his family, supported by their MP Steve Reed and INQUEST, Seni's Law, restricting the use of dangerous restraint practices against patients in mental health units came into force on 31st March 2022 - four years after it was passed. Aiming to improve transparency and accountability, it requires every mental health unit to publish its policy on the use of restraint, keep a record of occasions on which it is used, and designate one person who is responsible for implementing the policy. There was no police body-worn footage of Seni's restraint. Police officers who attend mental health settings now have to wear and operate body cameras.



Aji Lewis speaking to INQUEST

Seni's mother, Aji, a retired lawyer and former teacher, is certain racism played a part in her son's death. "Of course! We're a Black family. You cannot live in our skin and not know. This is our reality." The family wanted racial discrimination to be investigated by the IPCC and considered by the inquest jury. "We expected it to be there. It was an issue. We wanted it there," Aji says.

She felt able to discuss this with the family's solicitor, who acted on their wishes to get the issue heard. But despite efforts to get the watchdog and coroner to ask questions about whether police racism played a part in Seni's death, the subject is conspicuously absent from the investigation outcomes and inquest conclusions.

The IPCC, after considering the matter, concluded that the officers involved would not face a misconduct or gross misconduct disciplinary hearings on the grounds of race or mental health because there was not "enough evidence" to "distinguish sufficiently" that the explanation for the officer's use of force and level of restraint was discriminatory.

The decision did not surprise Aji, who by the time of the report's release, was well-versed in other families' failed struggle for accountability. "We'd already got word that they [the IPCC] were useless. Because you go into the process thinking 'everything will come out. They'll do a proper investigation.' By that time, we'd met loads of other

families, so we knew they were incapable of doing a thorough, robust investigation. They were incapable of looking at the issues. They just close ranks and can't face the truth," Aji says.

coroner refused on the basis that there was no evidence that race had played a part in Seni's death. The same arguments were also made by Metropolitan Police and Police Federation lawyers.

> **"The same language comes up at inquests where Black people are concerned. They spew out the same thing, 'big, black and dangerous'.**

At Seni's inquest – seven years after his death – the family wanted to question the officers involved about the extent to which their actions were shaped by their perception of Seni as a young, Black man and about the guidance and training they had received about racial stereotypes and bias. "We had two days of argument about it," Aji says. The

However, a few days later, the coroner referred to race as "the elephant in the room," Aji says. The apparent contradiction once again failed to surprise her. "It confirmed what we already knew: that there is no accountability. They know. It's staring them in the face, but they just don't acknowledge it. They just can't acknowledge it.

They don't have the guts. They don't have the honesty to acknowledge it."

The years spent fighting have destroyed all expectations that accountability – on any grounds – is achievable. "Listen, there is no accountability. You can wish and hope, but the raw fact is, you're not going to get it. People think 'oh there is going to be justice'. There is never justice until the state comes clean – about what they've done; what they do."

Aji says the police treated Seni as if he were an animal, rather than human. "They treated him in such an appalling way. No empathy. No thought. And the same language that comes up at inquests where Black people are concerned. They spew out the same thing, 'big, Black and dangerous They don't even have the gumption to use different words."

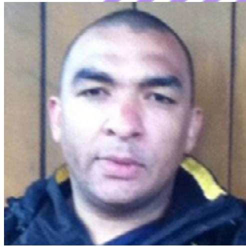
Although the murder of George Floyd has "galvanised" people, Aji is concerned that Britain is too focused on police-related deaths of Black people in

the United States. "People in Britain are looking at America. They don't know what's happening here."

What makes her most incredulous, however, is the way the state resists being held accountable for these deaths. "It beggars belief. I'm dumb founded that they can go on thinking that to ignore or to bury it is going to solve the problem. It doesn't. But who am I? Just an ordinary citizen who has lost her son."

> **"They treated Seni in such an appalling way. No empathy. No thought.**

Leon Briggs



Leon Briggs, a 39-year-old lorry driver and father of two children, died in 2013 after police officers restrained him face down in the street for more than 13 minutes, handcuffed him and put him in leg restraints. He was lifted into a police van and detained under the Mental Health Act at Luton police Station, Bedfordshire, where he was again restrained by officers then left unconscious for over six minutes, before becoming silent and unresponsive. He was taken to hospital, where he was pronounced dead.

Police were called after Leon was seen behaving strangely, walking and skipping along the street, moving erratically in and out of shops and traffic. Several witnesses described that he appeared to have mental ill health and seemed confused.

The 2016 IPCC investigation considered whether the actions, decisions and responses of the police officers or police staff were influenced by Leon's ethnicity, but concluded it was not possible to "distinguish sufficiently," whether the officers' actions were "motivated by unconscious bias on the grounds of race or discrimination due to a combination of Mr Briggs' mental ill health and race."

The IPCC referred the case to the CPS in the same year for a decision on whether manslaughter charges should be brought against several officers. **It took a further two years for the CPS to decide no criminal prosecutions would be taken.**

In February 2020, Bedfordshire police were to carry out a gross misconduct hearing against five police officers involved in the restraint and death of Leon. The misconduct hearings had been due to consider allegations against three officers for breaching the standards of professional behaviour in relation to the use of force, and allegations against all five officers for breaching standards relating to "duties and responsibilities." Bedfordshire Police assured Leon's family it would robustly examine the actions of the officers in the proceedings, but at the last minute asked the IOPC to withdraw its direction to hold misconduct proceedings stating that, regardless of the IOPC decision, it would not present any evidence against the officers.

The IOPC agreed to withdraw its directions of misconduct and the hearing did not go ahead.

More than seven years after Leon's death, an inquest concluded the way in which police officers restrained Leon contributed "more than minimally" to his death. His primary cause of death was "amphetamine intoxication with prone restraint and prolonged struggling".

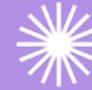
The jury found several serious police and ambulance failures, including a gross failure to provide Leon with basic medical attention and that there was a direct causal connection between this conduct and his death. They recorded a conclusion that his death was "contributed to by neglect." Officers failed to recognise he was in a state of medical emergency and did not monitor him in the police van and cell, which also contributed to his death, the jury said.

The ambulance service acknowledged a series of failings before the jury began its deliberations, including a failure to assess Leon, communication failures and a failure to recognise and treat Leon as a medical emergency.

The coroner's Prevention of Future Deaths report issued last year was highly critical of the multi-agency policy concerning Section 136 of the Mental Health Act that gives police emergency powers, saying it was "not fit for purpose."

The report said it was clear from evidence heard at Leon's inquest that there remains "insufficient or inadequate instruction of both police and ambulance crew about the critical issues of recognising and responding to a medical emergency and the effects of restraint including positional asphyxia" of people detained under the MHA.

The report concluded that since even basic first aid could have made a significant difference in Leon's case, "it seems critical that the close monitoring of a detainee who has been subject to restraint should be guaranteed in **all** cases." [Coroner's emphasis].



Margaret Briggs speaking to INQUEST

Leon's mother, Margaret, had never heard of death in custody and was not familiar with the names of Black or mixed-race men who had previously died following contact with the police involving use of force before Leon's death. Despite this, she had no doubt when she first saw Leon's "bruised" body that race had played a part in his death. "I stood outside the coroner's, and I said to my daughter, 'if I didn't have mixed-race children, it wouldn't have happened'."

"It was discrimination all the way," Margaret says. "What they [the police] perceived Leon to be, Leon wasn't. He wasn't aggressive. He wasn't out there to hurt anyone. He needed help. He was on the floor and he wasn't getting up to attack them as they thought. He wasn't doing anything. He was motionless. He wasn't faking his own death. He died there."

> **It was discrimination all the way**

Margaret is White, but says she has long faced racist attitudes about having mixed-race children. "When I saw Leon, like that, I thought it must be racial discrimination. I've always been excluded from most things, because of where I live and my kids being Black."

> **The process is for the police. The whole process was to protect them, to say they were right and they could have their jobs back.**

She knew also that in the past Leon, when he was well, had been pulled over and stopped and searched by the police a handful of times. "Leon could just go down the road, on his day off, and he'd be wearing a leather jacket and driving, and the police would stop him," Margaret says. "He was being taken to the station. I used to say, 'why didn't you call me?' And he'd say, 'Nah. I knew I was going to get out because they've got nothing on me."

When Leon died, one of his brothers began looking at other cases for answers about how to get justice for Leon. "We were getting in touch with other families in London and all over the country that had lost their loved ones in very similar ways," she says. "We realised there were other people, Black people, that have had the same treatment."

What Leon's brother also learned was that no police officer had ever been held accountable for these deaths. "He said that all the police stick together," Margaret says. "They stick together on it, and they come out. They're above us. And they've done it before and before and before."

Immediately after Leon's death, before experiencing the IOPC and inquest process, Margaret believed accountability was

possible. "But now, no, no. The process is for them [the police]. The whole process was to protect them. To say that they were right and they could have their jobs back," she says.

The delay of more than seven years between Leon's death and the inquest meant the family "having to grieve all over again," Margaret says. "It was another crash for my whole family, to go through the nine weeks of the inquest."

Whether race influenced the way in which Leon was treated by the police was not among the questions the jury considered at his inquest. "I knew it was only going to be skimped on the surface. It was taken out. It's not how I would have wanted it," Margaret says. "I thought, 'oh my God, it's just pushing it under the carpet. I don't want it to be pushed down.'"

Determined to bring race into view, Margaret said in her press statement following Leon's inquest in 2021: "We think that Leon's race was a factor

> **I wanted it out in the open. I want people to know why Leon died.**

in the way he was treated by the police. He was treated as someone who posed a threat rather than someone in need of help."

Margaret spoke out to try and stop others from dying the way Leon did. "That was the best thing I could have said. I wanted it out in the open. I want people to know why Leon died; to let everybody know what happened to Leon Briggs. That was my answer. And that was the truth."

Adrian McDonald

Adrian McDonald, a 34-year-old engineer and father of two children, died in 2014 in Newcastle-under-Lyme, Staffordshire in the back of a police van after repeatedly telling police officers, "I can't breathe." He had been restrained, bitten by a police dog, Tasered, and then placed in the van where he lost consciousness. Nine minutes passed before an ambulance was called but Adrian was pronounced dead at the scene.

Police were called after Adrian became paranoid after taking cocaine and barricaded himself into a room in a flat where he had been attending a party. The arriving sergeant told Police Control that the man in the flat seemed to be deranged with some kind of temporary impairment of mind, rambling and subject to delusion.

The report by the IPCC into his death in 2016 includes no mention of Adrian's race and racial discrimination is not in its terms of reference. It directed Staffordshire Police to bring gross misconduct charges against a sergeant and an inspector for their failure to treat Adrian as a medical emergency at the point he said he could not breathe. The watchdog also directed misconduct for the same charge against another officer, but they were later cleared and did not face a hearing.

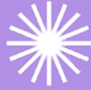
The disciplinary hearing cleared the sergeant and inspector of the sackable offence of gross misconduct. They were instead found guilty of the lesser charge of misconduct for delays in checking up on Adrian. However, in 2018 the officers successfully appealed against the charges, with the Police Appeals Tribunal citing a "misunderstanding" at the original three-day hearing. The written warnings the officers had received were struck-off their records.

The inquest in the same year did not consider whether racial discrimination was a factor in Adrian's death. The jury concluded that due to Adrian's cocaine induced paranoia, the level of force used may have increased his stress levels, which may have in turn contributed to his death.

The jury heard evidence that Adrian had five dog bites on his body. The bites went through skin, fat and into muscle tissue. Police van and body camera footage of the last minutes of Adrian's life were shown at the inquest. The jury found: "This would have been the appropriate time to complete welfare checks and assess the deceased's condition." Welfare checks did not take place.

The footage shows Adrian breathing heavily and slumped in the cage area of the van. He says, "I can't breathe," four times as well as "please." At one point an officer replies: "You can breathe because you are talking. Deep breaths." The jury noted that the officer was coaching Adrian to breathe. No ambulance was called. Shortly after, Adrian lost consciousness. A further nine minutes passed before an ambulance was called. Adrian was pronounced dead at the scene.

Following Adrian's inquest, the coroner did not issue a Prevention of Future Death Report, an important mechanism by which to improve public health, welfare and safety. A coroner has a duty to take action to prevent future deaths where anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist in the future; and in the coroner's opinion, action is required to prevent the continuation of such circumstances, or eliminate or reduce the risk of future death created by them.



Germaine Phillips and Wayne McDonald speaking to INQUEST

Adrian's brother, Wayne, an NHS mental health nurse, has been brought up to respect the police and trust the law, and so the role that race might have played in Adrian's death wasn't the first question he wanted answered when he learned his brother had died. Neither was it in the mind of Germaine, their mother, also a mental health nurse.

But discovering how the police treated Adrian, and Staffordshire Police's "vilification" of him to justify their actions, has left them in no doubt that the officers' treatment of Adrian was influenced by his race. "If it were a White person, would they have treated that White person the way they treated Adrian - worse than an animal?" Wayne says.

"One minute they were saying that he was in need of care. And then the next thing they're Tasering him while he was getting bitten by a dog. To me, that is not care. It's all aggression. All they showed Adrian that night was aggression. There was no care."

For the family, the justification for the police's use of force they heard during the IPCC investigation and inquest was linked to stereotypes about Black men. "They would focus on how big he was; how powerful he was; how crazy he was, as if to say, 'he's a big, strong, Black man'," Wayne says. "They never really questioned how vulnerable he was. And he was scared. They never once questioned, 'Well, there was eight of you and one of him'."

News of Adrian's death was reported in the media before the family were told. When the police liaison officer eventually came to Germaine's home, she says she was struck by how he seemed to show no compassion towards Adrian or the family, but instead referred to how "crazy" he was and the alleged condition of the police dog that bit him five times. "I felt, 'hang on a minute, are you just telling me this because Adrian's a Black man? You don't know the circumstances of the case. You're trying to cover up exactly what's happened to Adrian. You're making me feel that Adrian is the bad one there.

> **All they showed Adrian that night was aggression. There was no care.**

He's the devil. He's the evil one. So the officers with their dog and everything had every right to do what they did to Adrian'."

Germaine says that while she was waiting for the visit, police officers went to Adrian's partner and the mother of his children to tell her Adrian had died, and then questioned her about whether he had ever been abusive towards her.

Wayne had heard the early news reports about the death of an unidentified man but never imagined it could be his brother. This was because the unnamed man was referred to as "a suspected burglar" – wrong information given to the police when they were first called but which continued to be circulated in police and IPCC statements. "And I knew Adrian was no burglar," Wayne says. When the family asked the IPCC to remove the reference to "burglary" from any further statements, they were told doing so would "jeopardise the case." Adrian's friends tried to set the record straight on local radio and told the IPCC

that he had been at the flat for a party and wasn't a burglar. It came down to the family to trawl through statements and paperwork themselves to force the watchdog to stop the misinformation being repeated.

The abuse contributed to the family's decision not to speak about race during the investigatory process. "We didn't have a chance in getting justice anyway.

> **George Floyd said the same thing as Adrian: 'I can't breathe'. When Adrian says, 'I can't breathe', the officer's telling him 'well, you're talking aren't you'**

As well as causing the family hurt, the false statement also generated abusive comments from the public on social media and online comments in the local newspaper, expressing the view that Adrian deserved to die because he was a burglar. "People were saying 'he f-ing deserved it'; 'he's bloody this and that'; 'he's a burglar'," Wayne says.

But I think we would have had less of a chance if we would have brought race into it," Wayne says. "We couldn't. We were backed into a corner where we were vulnerable ourselves."

The imperative was to protect Adrian's young family and limit "all the negativity" about their father. "We could see that

> **We knew they were incapable of doing a thorough, robust investigation. They just close ranks and can't face the truth.**

the public was already on the police's side. So we didn't want to start saying 'it's a Black thing' because the public perception is, 'oh you're just playing the race card'," Wayne says. "If we would have said at that point, 'he's dead because he was Black', the abuse would have been a hundred times worse than we were getting already."

He believes that the IOPC and inquests should automatically consider include the question of whether racial discrimination played a role in deaths of Black people following police contact. "It would have been nice if those [investigatory] bodies would have brought it in, without us having to bring it in for ourselves. We would have just got more abuse when we're already going through enough. Those bodies should have just asked the questions for us."

In her working life, Germaine has experienced rebuffs and resistance when raising the subject of racism and wanted to avoid such a response when it came to getting answers about the death of her son. "They'll say, 'Here you go again; she's trying to play the race card'. You have to just get on well with these people, because you want the truth. And if you start [talking about race] they'll say, 'here we go again: a Black family that's very aggressive, militant'."

Moreover, the family trusted that the legal processes following Adrian's death would deliver justice. "I thought everything's there. They say they needed the facts. They don't want anything else but the facts. I thought you've got all the facts there," Germaine says. But the family's experience of the IPCC investigation, inquest and misconduct proceedings has destroyed their faith in these processes bringing accountability. "Nobody helped Adrian. Nobody. Nobody," Germaine says. "And we're still fighting. The people that we thought would have helped us. They let us down," Germaine says.

The family consider the IPCC investigation into Adrian's death a "farce," Wayne says: "We quickly learned that the police were in control of the information; what information we got. They control what the IPCC got. If we ask for something, the IPCC have to go back and ask the police if they could have it. It's not really an investigation because you can't investigate something when it's not transparent."

"The police, the IOPC, the coroner, the CPS: none of them really wanted us to get justice. If they did, we would have got justice for Adrian. There was enough evidence there," says Wayne.

"George Floyd said the same thing as Adrian: 'I can't breathe'. When Adrian says, "I can't breathe," the officer's telling him 'well, you're talking aren't you'. The whole culture has to change. If somebody's saying they can't breathe, they should be taking that very seriously. Especially after putting somebody through what he'd been through," Wayne says.

"How did the police help him? We're still wanting that answer now. So that's why we have to carry on fighting. We're his voice now."

Darren Cumberbatch

Darren Cumberbatch, a 32-year-old electrician, died in hospital in Warwickshire in 2017, nine days after the use of force by police officers while he was experiencing a mental health crisis.

Police were called by staff at the bail hostel in Nuneaton where Darren was staying after he became agitated, paranoid and afraid. He had a history of depression and anxiety. After officers arrived, Darren went into a small toilet cubicle where he was safe. Without any discussion amongst themselves, or any plan, seven officers entered the cubicle. In the course of the next ten minutes Darren was punched 10-15 times; struck with batons; kicked, stamped on; Tasered 3 times, sprayed with PAVA incapacitant; handcuffed and restrained on the ground in the prone position.

Officers pulled Darren out of the cubicle and further restrained him, including in the prone position, in the corridor outside the toilet and he was lifted and dragged to the police van in which he was driven to hospital. He was again restrained on the ground in the hospital car park. While handcuffed, further restraints were applied to his thighs and ankles for 40 minutes – in excess of the 20-minute guideline. As he entered the hospital Darren was hyperventilating, sweating and his heart rate and temperature were high. He was placed on a trolley on his back and made to lie on his handcuffed hands. He remained in handcuffs and leg restraints and at times he was held down by police officers. He appeared distressed and asked for help. He told doctors he had taken half a gram of cocaine and cannabis.

Darren's condition rapidly deteriorated and he was transferred to the Intensive Treatment Unit suffering from multi-organ failure. Darren survived for over a week in hospital, but Warwickshire Police did not report the incident to the IOPC until after he died. Evidence was therefore lost.

Establishing whether any acts or omissions of any police officers were motivated by Darren's ethnicity was not included in the IOPC investigation terms of reference. At the end of their investigation in 2018, the IOPC concluded that "there was no indication that any officer may have breached the standards of professional behaviour or that they had a case to answer for misconduct," but that the publication of its report would "await the conclusion of an inquest." No police officer involved has faced disciplinary proceedings or criminal charges.

The inquest jury concluded in 2019 that police use of "considerable restraint" on Darren contributed to his death which "may have been excessive" and was "at times probably avoidable."

One officer involved reportedly admitted making incorrect statements on police notes after the event and copying[38] another officer's notes word for word in his account of the incident.

The jury also found serious failures in the police officers' communications, which were ineffective, and noted the failure to have a meaningful plan to respond to Darren before entering the cubicle.

The medical cause of death was multiple organ failure as a result of cocaine use in association with restraint and related physical exertion.

Despite these findings, the coroner's Prevention of Future Death report addressed only the probation service, calling for hostel probation staff to receive more training to de-escalate situations.

[38] ITV News. (2019). Inquest concludes police restraint contributed to death of Darren Cumberbatch. ITV News. Available at: https://www.itv.com/news/central/2019-06-25/inquest-rules-police-restraint-contributed-to-death-of-man-after-arrest-darren-cumberbatch

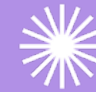
The jury finding was at odds with the IOPC findings and so the watchdog announced it would "review" its investigation by comparing the evidence from the inquest to that gathered during its own investigation. To do so, it required transcripts of the inquest. However, it took more than a year for the IOPC to obtain the transcripts

It took a further nine months for the IOPC to decide it would not re-investigate – despite identifying six areas where its investigation was lacking. The family threatened to have the decision judicially reviewed. The IOPC then said it would re-review the decision. In July 2022 - more than three years after the end of Darren's inquest - the IOPC said it would reinvestigate Darren's death as its original investigation was "materially flawed in a manner which had an impact on the subsequent decisions made on discipline, performance and/or referral to the Crown Prosecution Service."[39] The IOPC will now look at the officers' entry into the toilet cubicle in McIntyre House where Darren had retreated, and their subsequent use of force.

Darren's sister, Carla, contributed to the IOPC's review into the police's use of Taser, published in 2021.[40] It found that Police deploy Taser stun guns too often, with Black people more likely to face prolonged use lasting over five seconds. The IOPC said that, of the cases it reviewed, 60% of Black people who were subject to Taser discharges endured them for more than five seconds, compared with 29% of White people. It also found that mental health played a key role, concluding that the intersectionality of race and mental health can increase the risk of higher levels of use of force.

[39] Independent Office for Police Conduct. (2022). IOPC announces reinvestigation into police contact with Darren Cumberbatch prior to his death. Independent Office for Police Conduct. Available at: https://www.policeconduct.gov.uk/news/iopc-announces-reinvestigation-police-contact-darren-cumberbatch-prior-his-death

[40] Independent Office for Police Conduct. (2021). Review of IOPC cases involving the use of Taser 2015 – 2020. Independent Office for Police Conduct. Available at: https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/IOPC_Taser_review_2021.pdf



Carla Cumberbatch speaking to INQUEST

Until George Floyd's murder Darren's older sister, Carla, says she did not have the confidence to speak out about how she understands his death. "I couldn't find the words." But when the protests in Britain seemed to her largely focused on the situation in the US, she found her voice. "In England, everyone was talking about George Floyd. In the news. In politics. But we've got our own problems in our own backyard. Joy Gardner. Christopher Alder. I could sit here all day, Smiley Culture, Darren Cumberbatch, Cameron Whelan, Sean Fitzgerald, Marc Cole, Adrian McDonald."

In the face of "the lack of candour; the lack of transparency and the lack of accountability" following Darren's death, Carla has endeavoured to become an expert on the law. She has made a concerted effort to be informed of other deaths involving the police following use of force; statistics; reports and any recommendations relevant to Darren's case.

> **"Darren died because he was a Black man... He was scared. It was a medical emergency.**

"And it's worth it. My nickname for my brother was my 'wingman'. When I had a problem, I used to go to him. I've got no one to go to now. The only thing I've got is my kids and myself."

When Carla saw Darren "battered black and blue" before he died in hospital in 2017, she believed racism had influenced the way the police treated him. However, she says she "didn't really acknowledge it," publicly at first.

But the ongoing five-year struggle to find out the truth about what exactly happened to Darren, and who was responsible, has changed her. "I used to sit and not say anything; not challenge something. This has taught me to speak up. This has taught me to say what I see."

She is clear about what she believes happened to her brother. "Darren died because he was a Black man," Carla says. "Darren wasn't

> **"In England, everyone was talking about George Floyd. But we've got our own problems in our own backyard. Joy Gardner. Christopher Alder, Smiley Culture, Darren Cumberbatch, Cameron Whelan, Sean Fitzgerald, Marc Cole, Adrian McDonald."**

acting violently; threateningly; using verbal diarrhoea or anything. He was scared. It was a medical emergency."

Carla has watched what CCTV footage there is of the police's contact with Darren. "Instead of assessing Darren; instead of calming him down; instead of speaking to the people [in the hostel] about Darren's mental health; instead of calling the ambulance - they call for backup. They come in twos. But two officers ended up with 11, including an inspector and a sergeant. Why was it done?" she says. "You can't treat a dog or a cat like that."

Carla says it was the hospital, not Warwickshire Police, who contacted her to tell her Darren was there – three days after he had been admitted – but no one gave her details about what had happened to him. She became increasingly concerned after someone falsely claiming to be a member of the family called the hospital asking for information about Darren's condition. "That set off alarm bells. I decided 'I'm not leaving him'." She suspected the caller was a member of the police and so ensured either she or someone from her trusted circle was with Darren at all times during his last days.

> **"Instead of calling an ambulance, they called for backup**

"I've seen him battered by the police before," Carla says. "I know how Black people are treated by the police. I've been pulled. I've been stopped-and -searched. I've been looked at; had people move away from me on the bus. I've had working environments where I had to go to the union and say 'excuse me, I've had these racial comments. I'm having stuff put in my locker. I can't take it no more.' And it was ignored."

The fact that the terms of reference in the IOPC investigation did not include whether Darren's ethnicity had any bearing on the actions of the officers involved is "disgusting," Carla says. "It's a disrespect because it's obvious. It's degrading to Darren because, with all these policies [regarding the IOPC investigating racial discrimination], what are they there for if you're not using them?"

> **He's got to rest in power. They took his power away from it, but they can't take his voice away from him. Because that's me.**

For families to raise the question of whether racism was a factor following a death involving police contact, they need "not to be judged," Carla says. "And for it to then be thoroughly, robustly dealt with. And there needs to be a follow up. Who's checking the recommendations are implemented?"

The IOPC failed her, Carla says. She raised concerns about the investigators' lack of scrutiny of the conduct of the officers throughout the investigation. She still has no final report five years after Darren's death and has lost all faith in the watchdog.

"They do their shoddy reports that are not in the public's interest and only favour the police. If I was to do the same [as the police in Darren's case] I would be held accountable, and it would be a transparent investigation; a robust one in a timely manner."

The initial time frame given by the IOPC for the report was eight months, Carla says. "How many eight months have gone into five years? How much patience do you expect me to have? When are you're going to do your damn job?"

Bereaved families are "pushed from pillar to post" by the authorities, Carla says. "We are disrespected and treated with disdain."

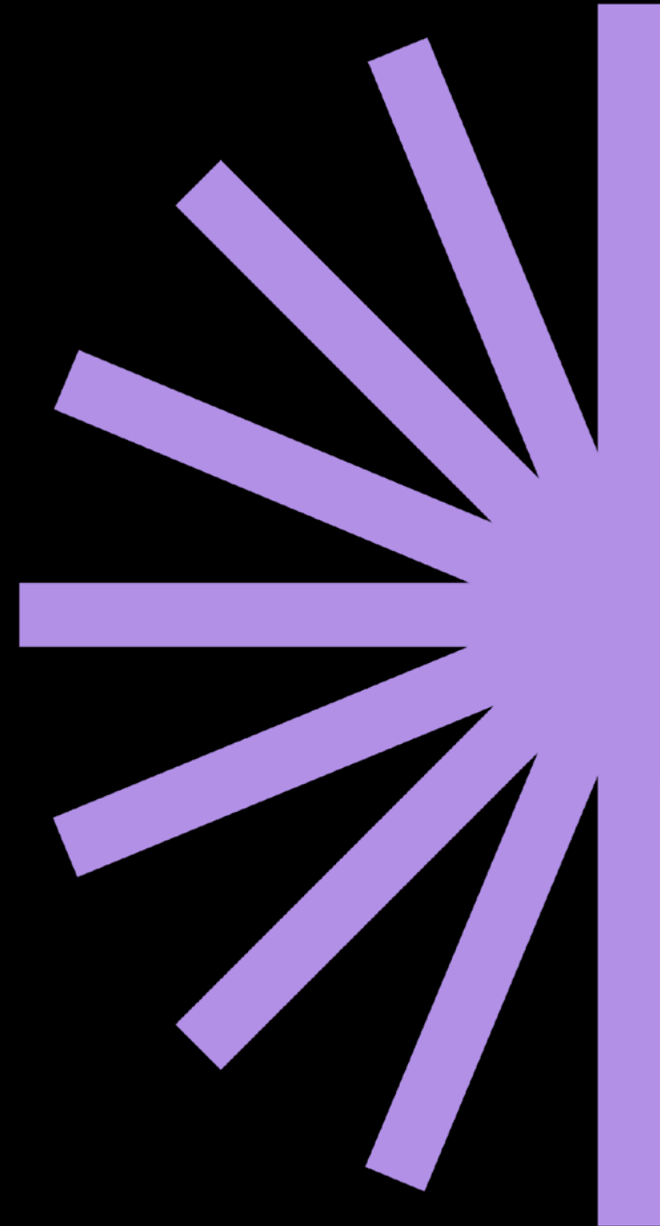
Although the inquest was "the closest to the truth," Carla has got in finding out what happened to Darren, it did not deliver the accountability she seeks. "I was waiting for something. Like a result. When I understood the result, I realised that I felt the same way as I did when I walked in there. I was confused again. What was I in that for? What was that about?"

And so, she continues to fight for the IOPC to re-investigate Darren's death, aware of the personal toll that takes. "How long's a piece of string? The system's not designed for me. I could be fighting for 20-something years. How am I meant to do all the research for this and maintain my children? How am I to have a life? Sometimes I've had to push myself to do it. Don't want to get out of bed."

"But I've got something to live for. I've got life - something Darren hasn't got. I've stopped saying 'rest in peace'. He's got to rest in power. They took his power away from it, but they can't take his voice away from him. Because that's me."

Following this interview, the IOPC admitted its investigation was "flawed" and announced its re-investigation. Carla says it is "galling" to the family that this is now five years after her brother died.[41]

[41] INQUEST. (2022). Darren Cumberbatch: Police watchdog announces rare reinvestigation of restraint and death of Black man. INQUEST. Available at: https://www.inquest.org.uk/darren-cumberbatch-reinvestigation



05

The Legal Process

The Legal Process

Why are police officers not held accountable for racial discrimination following a death involving police contact when the law, guidelines and expert recommendations say that if there is any suggestion of racial discrimination this should be explicitly referred to and addressed in the investigation process?

To answer this question INQUEST conducted **in-depth interviews with 12 of Britain's leading human rights lawyers** – eight solicitors and four KCs - with long standing expertise in cases involving the deaths of Black people following contact with the police. They have worked on some of Britain's most significant cases, representing bereaved families[42] through the legal stages that follow such deaths.

INQUEST's unique access to this legal expertise, together with the organisation's own specialist knowledge developed from four decades of casework, provides an unparalleled insight on this issue.

We asked the lawyers to give their legal perspective as to what prevents robust investigation into whether racism played a role in these deaths, and what needs to change for accountability to be brought.

This section outlines their key areas of concern in the three investigatory processes which usually follow a police-related death: the IOPC investigation; the inquest and consideration by the Crown Prosecution Service.

[42] INQUEST has maintained contributors' anonymity

1 Why role of race should be investigated by the IOPC

The IOPC's guidelines for handling allegations of discrimination, defined by the Equality Act under which race is a protected characteristic, are comprehensive and detailed. They apply not only when discrimination is alleged but "where no specific allegation of discrimination has been made but it is apparent that discrimination may be a relevant consideration."[43]

The broader context within which these guidelines operate is that Black people are – by multiples – far more likely to be stopped by police – both in their cars and in the street; far more likely to be searched; far more likely to be handcuffed and subjected to force; and far more likely to be strip-searched than people of other ethnicities.

They are, in other words, far more likely to have an adverse experience with police. As this INQUEST report makes clear, official data shows that Black people were seven times more likely to die than White people when restraint was involved.

Lawyers said that the social context in which deaths took place puts beyond doubt that, where a Black person dies following police contact, the IOPC must investigate whether race played a part. But they often do not. Given the huge social importance of racial disparities in policing, lawyers said that race should be at the heart of these investigations and the lines of inquiry pursued need to be capable of exploring this.

[43] Independent Police Complaints Commission. (2015) IPCC guidelines for handling allegations of discrimination. Independent Police Complaints Commission. Available at: https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/guidelines_for_handling_allegations_of_discrimination.pdf

1.1 The IOPC can't deliver accountability without candour and will from the police

The police watchdog operates in a highly charged environment where allegations of racial discrimination are considered damaging and are heavily resisted due to organisational reputation management for the force and because, especially in the case of deaths, a finding of racial discrimination against officers would have serious professional consequences. This appears to inhibit the IOPC's willingness to act. It risks being paralysed, as one lawyer said, "more fearful of a backlash than not doing its job."

Lawyers said that without the police themselves being more open to scrutiny, the IOPC cannot deliver accountability. There is a well-documented defensiveness and lack of openness in the way police respond to processes of accountability.

Last year Cressida Dick, the former Commissioner of the Metropolitan Police, was accused by the government-sponsored inquiry into the murder of private investigator Daniel Morgan of obstructing access to key documents. The Daniel Morgan Independent Panel described the Met as "institutionally corrupt," where this was defined as "dishonesty on the part of the organisation for reputational benefit."[44] The Panel argued for the creation of a statutory "duty of candour" to be applied to all law enforcement agencies.

This call was first made five years ago after the denial and obfuscation of another police force was exposed. In November 2017 the Bishop's review of Hillsborough families' experiences called for the police to be subject to a legal "duty of candour"[45] after officers failed to cooperate fully with investigations into alleged criminal offences or misconduct

[44] The Daniel Morgan Independent Panel. (2021). The National Archives. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20220331104048mp_/https:/www.danielmorganpanel.independent.gov.uk/wp-content/uploads/2021/06/Media-Briefing-statement-Final-NOL-09.06.21-printing__-version.pdf

[45] Jones KBE, T.R.R.J. (2017). 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated. Home Office. Available at: https://www.gov.uk/government/publications/hillsborough-stadium-disaster-lessons-that-must-be-learnt

regarding the disaster. Earlier that year the Angiolini Review had called for a similar obligation to be placed upon officers. It concluded: "it is clear that the default position whenever there is a death or serious incident involving the police, tends to be one of defensiveness on the part of state bodies."[46]

By November 2021 ministers said the government was considering a "duty of candour" as part of their response to the Hillsborough report, and that it wished to engage with the bereaved families before going ahead. Ministers defended the government saying they had acted with respect to the police by introducing a "duty of cooperation" in 2020 when the Police's Standards of Professional Behaviour were changed to clarify that failure to cooperate with investigations and inquiries could constitute misconduct.[47]

The Home Office guidance issued in February 2020 says that the responsibility (for a police officer) "is to participate openly and professionally as a witness in a variety of circumstances including where the officer is a witness in an investigation into other officers' misconduct, be that an investigation by the Independent Office for Police Conduct (IOPC) or by the force itself."[48]

However, this change has yet to have made any appreciable impact in how the IOPC works. As the Home Affairs select committee noted in February 2022: "There is a clear absence

[46] Angiolini, D.E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

[47] Hansard. (2021). Law Enforcement Agencies: Duty of Candour. House of Lords. Available at: https://hansard.parliament.uk/lords/2021-06-22/debates/1C01DC8C-5C59-40E1-8B22-D901F6005D53/LawEnforcementAgenciesDutyOfCandour#:~:text=To%20ask%20Her%20Majesty's%20Government,serve%2C%20subject%20to%20protection%20of

[48] Home Office. Home Office Guidance – Conduct, Efficiency and Effectiveness: Statutory Guidance on Professional Standards, Performance and Integrity in Policing. Home Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863820/Home_Office_Statutory_Guidance_0502.pdf

of urgency and a culture of non-cooperation from some police forces involved in investigations." [49]

The IOPC has not in the last two years invoked the duty of cooperation. The Police Federation claims this is evidence that officers "do comply with investigations."[50]

The IOPC remains under the spotlight. The then Home Secretary Priti Patel announced in 2021 that she was bringing forward the first periodic review of the IOPC. She said "questions remain about its ability to hold the police to account,"[51] citing concerns over the IOPC investigation into the handling of false claims of sexual abuse in Westminster.

Accountability requires the police, at an individual and corporate level, to acknowledge that racism and racially discriminatory conduct in policing exists and must be tackled, and that they need to work with the IOPC to address it. Currently, defensiveness runs through both rank and file and senior leadership, and this is nowhere more evident than in how forces respond to police complaints of discrimination. Lawyers representing complainants tell of 'tick box' responses to such complaints; of complaints being dealt with informally instead of being referred to the IOPC; of investigators putting the onus on complainants to 'prove' they were discriminated against and of a seeming culture of 'protecting' both the officer and the force from such accusations.

[49] Home Affairs Committee. (2022). Police Conduct and Complaints. House of Commons. Available at: https://committees.parliament.uk/publications/9006/documents/166181/default/

[50] Polfed News. (2022). PFEW response to recommendations set out in Home Affairs Committee report. Wiltshire Police Federation Available at: https://www.polfed.org/wiltshire/news/2022/pfew-response-to-recommendations-set-out-in-home-affairs-committee-report/

[51] Hansard. (2021). Daniel Morgan Independent Panel Report. House of Commons. Available at: https://hansard.parliament.uk/commons/2021-06-15/debates/73BB602C-F53E-4EBF-88B2-2E76F6566F07/DanielMorganIndependentPanelReport

One example given of this was when Cressida Dick pre-empted the findings of an IOPC investigation in the summer of 2020 by defending her officers who had handcuffed two Black athletes in front of their three-month-old son during a stop and search in west London. Her deputy then told the Greater London Authority that two sets of the Met's own professional standards team had reviewed the case and neither "saw anything wrong with it."[52] The lawyer giving this example told INQUEST that such behaviour from senior leadership in the police not only led to "a sense of impunity, but a failure to actually allow officers to learn."

The IOPC concluded in April 2022, after Dick stepped down, that there was a case to answer for gross misconduct – including breaching standards on equality and diversity - against five Metropolitan police officers.[53]

Chief Constables must, of course, deal with competing interests and have to balance these to keep the confidence of their own workforce. However, it seems to be accepted that if a Chief Constable was, in the words of one interviewee, "not supportive of rank and file officers [they would] have the Police Federation to answer to."

There are one or two examples of good practice - one lawyer said there were some "promising signs" that within police leadership there was a recognition of racist conduct, and how the perception of lenient treatment for it, damages public confidence. They pointed out that in 2019[54] and 2020[55] two Chief Constables successfully challenged the weak sanctions imposed by police misconduct panels for officers found to have used racist language.

[52] Weaver, M. and Dodd, V. (2020). 'Police treated unfairly over incidents caught on video, says senior Met officer'. The Guardian. Available at: https://www.theguardian.com/uk-news/2020/jul/15/police-treated-unfairly-over-incidents-caught-on-video-says-senior-officer

[53] Dodd, V. (2022). Police who handcuffed Bianca Williams to face gross misconduct charge. The Guardian. Available at: https://www.theguardian.com/uk-news/2022/apr/26/police-who-handcuffed-bianca-williams-to-face-gross-misconduct-charge

In one case, the Panel had assessed that racist conduct towards a fellow officer had been "provoked." The high court judge who quashed the panel's decision described its finding as "sufficiently inexplicable as to be properly described as irrational." Her judgment, said lawyers, should be incorporated in training for all those investigating police complaints of race discrimination.

1.2 Cultural resistance within the IOPC to investigate racism in relation to deaths

Our panel of lawyers told us they were not aware of any case where an officer had been found by the watchdog to have a case to answer on the grounds of racial discrimination following a death. This was confirmed by the IOPC in responses to INQUEST's freedom of information requests from 2015/16 to 2020/2021.

Lawyers describe an institutional reluctance within the IOPC to investigate police racism when someone has died. "What happens is a family raises it, because of the history, as another Black death in custody. And the IOPC often say, 'Well, that was a different set of circumstances. Different borough; different officers. And often, you know, they're not different sets of circumstances. They are the same. Which is the reason why the family say race has played a feature," said one lawyer.

That reluctance is apparent throughout the complaints system, with both the police and IOPC declining to name racism and discrimination even when this seems the overwhelmingly likely explanation for what has happened.

[54] Northumbria Police. (2019). PC who used racist language will not return to Force. Northumbria Police. Northumbria Police. Available at: https://beta.northumbria.police.uk/latest-news/2019/december/pc-who-used-racist-language-will-not-return-to-force/

[55] White, C. (2020). Misconduct panel's decision to impose a final written warning for racist remarks quashed by the High Court. UK Police Law Blog. Available at: https://www.ukpolicelawblog.com/misconduct-panel-s-decision-to-impose-a-final-written-warning-for-racist-remarks-quashed-by-the-high-court/

Without an acceptance and acknowledgement that race may indeed play a role in these deaths - as it clearly should do given other racial disparities in policing - the IOPC will inevitably fall short, leaving bereaved families and Black and racialised communities mistrustful not just of the police but also of their purported watchdog.

All too often, bereaved families have to resort to legal challenges in order to correct investigative failures. While these can be effective, one lawyer on the panel remarked that it was the IOPC, and not the bereaved, who should be tenaciously challenging and exposing police misconduct. Other lawyers commented on the lack of will on the part of IOPC investigators to ask the hard questions and show resolve when interviewing police officers who refused to cooperate. They saw it as a "matter of courage," on the part of the watchdog. They reported that the IOPC seemed to have confused independence with neutrality, preferring to sit on the fence and shy away from controversial decisions "They will never jump one way or another. Nobody gets anything from the process," said one lawyer.

The watchdog does not challenge the denial by some police forces that they are institutionally racist, including the UK's largest, the Metropolitan Police.[56] Lawyers attributed this partly to pressure the IOPC faces from the Police Federation,[57] representing the rank and file of officers, which invariably defends its members against allegations of racism and also denies that the police are institutionally racist, and possibly also to a pressure not to alienate senior police management.

1.3 The IOPC's investigatory failures

Complaints about the quality of police watchdog investigations have featured in every formal interaction between our lawyers and the IPCC/IOPC, throughout the life of both organisations. Consistent with that ongoing concern, there was a unanimous view among the lawyers that the IOPC is failing to robustly investigate racism in policing. They acknowledge that the task is challenging - including because police officers can be uncooperative and obstructive – but identify key areas where things are going wrong.

a) A failure to ask the right questions

Investigations by the IOPC into deaths of Black people following police contact routinely fail to ask officers probing questions about race, which should examine their views, their conduct history and their biases. This goes against the watchdog's own guidance on how to investigate possible racial discrimination. It would be a rare exception, lawyers said, to see an IOPC investigator exposing an officer to what might admittedly be an uncomfortable line of questioning.

One lawyer described how officers involved in a death of a Black man after he was restrained were not directly questioned at all by watchdog investigators about the influence the man's race might have had on their actions, and no inferences were drawn. This was despite the investigation's terms of reference including the issue. The IOPC recommended several of the officers face gross misconduct charges – but none on the grounds of race. "The officers were giving 'no comment' interviews. But they [the IOPC] also weren't putting direct questions to them about race so it's difficult to understand how they came to the conclusion they did."

b) A failure to look at the context

There is a marked reluctance to look at the bigger picture and take into account deaths which occur in similar circumstances; complaints' histories; stop and search records; issues within teams; the culture of different teams and forces and statistical

[56] Dodd, V. (2022). New Met commissioner declines to say whether force is institutionally racist. The Guardian. Available at: https://www.theguardian.com/uk-news/2022/sep/27/new-met-commissioner-declines-to-say-whether-force-is-institutionally-racist

[57] Donald, C. (2020). No, the police are not institutionally racist. The Telegraph. Available at: https://www.telegraph.co.uk/news/2020/08/21/no-police-not-institutionally-racist/

data on the disproportionate use of force. This means that appropriate inferences are often not drawn. "I've yet to see a case where the IOPC have conducted a proper investigation into race: looking at stereotypes; past evidence; potential racist thinking; asking the right questions; getting expert evidence from a race advisor. I've never seen any of that," one lawyer said.

Lawyers said the mind set of most IOPC investigators about the concept of race and what constitutes racial discrimination is antiquated and narrow. "Race looms large in restraint-related deaths, but it is never spelled out [in the IOPC investigation]." Seeking to distinguish deaths on the bases that they involved different officers or locations, for example, is to wilfully ignore the role of institutional racism.

c) A failure to understand and apply the law on discrimination

All too often, unless racism is expressed overtly in the form of verbal abuse or phone messages, the watchdog appears to conclude there is no evidence of racial discrimination. "They say, 'I haven't seen any evidence of racism,'. But, by that, what they mean is they haven't seen anyone using a racist term or saying, 'because you're Black I'm going to kill you'. That's far from adequate. I've never seen them, off their own backs, doing a proper investigation about [racial discrimination]," one lawyer said.

Given that direct evidence of discrimination is rare, and that individuals almost never admit they have acted in a discriminatory way, lawyers explained how the law had evolved to meet the challenge of assessing whether discrimination has taken place. However, they are concerned that the IOPC is failing to properly apply current legislation in its investigations, and in particular the provision within the Equality Act which reverses the burden of proof. This means in practice that if there is clear evidence of differential treatment on the grounds of race, it is for the police to provide a non-discriminatory explanation to prove "on the balance of probabilities, that the treatment was in no sense whatsoever on the grounds of [race]."[58] If they do not, a court would be entitled to make a finding of discrimination by inference.

Police officers have powers of detention and force and are required to justify their use of both. That justification has a subjective element which can only be exposed, if at all, by a robust scrutiny of their thought processes and the surrounding circumstances.

Several lawyers pointed out that IOPC does not need to make a finding of discrimination in these cases. All they need do is say that there is sufficient evidence of discrimination such that a properly conducted disciplinary panel could find this allegation proven, i.e., there is a case to answer, and let the issue properly be explored in that forum.

However, the IOPC's Guidelines for Handling Allegations of Discrimination,[59] adopted from the IPCC, do not spell out explicitly this shift in the burden of proof, and do not set out the obligations on investigators and police officers to give effect to that provision.

Generally, the IOPC do not tie the objective context to a failure to provide a properly non-discriminatory explanation, and the matter ends there. Lawyers said this amounts to the IOPC giving officers the benefit of the doubt. It also raises the bar for finding an officer has a case to answer for racism.

Lawyers said that a refusal by officers to give a non-discriminatory explanation in such cases by offering little beyond "no comment" to the

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[58] Igen Ltd v Wong [2005] IRLR 258, CA. Available at: https://app.croneri.co.uk/law-and-guidance/case-reports/igen-ltd-v-wong-2005-irlr-258-ca

[59] Independent Police Complaints Commission. (2015) IPCC guidelines for handling allegations of discrimination. Independent Police Complaints Commission. Available at: https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/guidelines_for_handling_allegations_of_discrimination.pdf

IOPC should, on its own, prompt the watchdog to find that there was a case to answer on the grounds of race. If this were to happen, officers who gave no satisfactory explanation would have to face a tribunal. That process comes with safeguards for the officer and the force, but also involves both in properly examining police conduct.

The burden of proof is of course properly applied in the civil courts, which means that the same set of facts can lead to the dismissal of a police complaint but the upholding of a subsequent civil claim for discrimination.

d) An atomised approach

IOPC investigations frequently fail to take proper account of context, focusing on each constituent part of an incident in a standalone fashion, which inevitably leads to a sterile and narrow focus in the investigation, where key issues such as race are obscured because they are not viewed in the round. This was described by one lawyer as "mastering the art of losing the impact of an incident as [the IOPC] investigates it, stripping out all of the meaning by atomising each part of the incident instead of taking a step back and looking at the whole picture."

The IPCC/IOPCs failure over a great many years to improve the quality of investigations has wider implications. Given that the watchdog continues at all levels to conduct investigations which only pay lip service to discrimination, it is perhaps not surprising to see local police investigations mimic that approach. The effect is to undermine the entire police complaints process. "The challenge for the leadership [of the IOPC] is how to make sure, not that the mistakes are swept under the carpet, not to make scapegoats of people who've made mistakes, but to encourage learning from those mistakes: to name the problem, so that it can be dealt with in the most constructive possible way," one lawyer said.

2 Coronial Inquests

In INQUEST's experience of supporting families through the inquest process for over four decades, the role racism might have played in a death of a Black person following contact with the police and the question of race is almost always absent from their inquests. It is rarely within the scope of the inquest, much less left to the jury to make findings upon.

The result is that race will be missing from the evidence heard and tested, from narrative conclusions and from Preventing Future Deaths reports. One lawyer said this amounts to an exploration of possible police racism being "short circuited" in inquests. "If an issue has not been explored in the inquest then, by definition, there is no evidence of it."

2.1 Impact of IOPC investigation

Lawyers emphasised how crucial the quality of the IOPC investigation could be to scrutinising race in an inquest. There is often a time lag of several years between a death and an inquest in cases involving the police. The watchdog's investigation has the opportunity to gather evidence immediately after someone has died and to seize records, including mobile phones and other digital data. A failure to take these steps early on can rarely be remedied later. This highlights the crucial importance of raising race during the IOPC investigation and pressing for it to be investigated from the outset.

In theory, an inquest is a separate, inquisitorial process in which the coroner must decide the scope of the inquiry and investigate. The coroner decides on what evidence is relevant and which witnesses to call; questions witnesses and directs the jury. But those inquiries

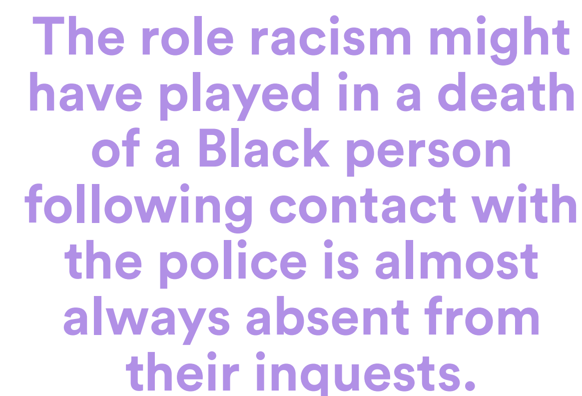
are very much shaped by the police or IOPC investigation which preceded the inquest. Some coroners simply adopt this investigation and require persuading to look any further and consider the role of race. The invisibility of race in these inquests therefore starts with the IOPC as, if the watchdog has not thoroughly investigated this, in all likelihood neither will the coroner. However, if the IOPC were to conclude an officer had a case to answer, it would make it difficult for a coroner not to include the subject in the inquest.

This reality places the responsibility on bereaved families to make representations asking the coroner to include the possible role of race discrimination in the scope of their inquiry. In spite of the burden this inevitably places on the family, their role in shaping the evidence means that an inquest is an important opportunity to bring accountability for the death of a Black person in custody or following police contact. When a coroner does not rest on the IOPC report and permits different issues and new evidence to be heard, an inquest jury can draw different conclusions from the watchdog which have in the past served to highlight the shortcomings of IOPC investigations.

This was most recently demonstrated in July 2022 when the IOPC said it would reinvestigate the death of Darren Cumberbatch,[60] after considering evidence from his inquest in 2019 which found police force may have been excessive and avoidable.

Several contributors emphasised that the lack of a thorough investigation by the IOPC into the role race might have played in a person's death, while unhelpful, should not deter families from making submissions that this should feature in the inquest. The importance of disclosure was also emphasised: even if

[60] INQUEST. (2022). Darren Cumberbatch: Police watchdog announces rare reinvestigation of restraint and death of Black man. INQUEST. Available at: https://www.inquest.org.uk/darren-cumberbatch-reinvestigation



the IOPC has concluded there is no case to answer for racial discrimination, the evidence gathered can be used by lawyers to persuade the coroner the issue should be included in the inquest.

However, this does not always happen. In some cases, it was felt that not doing so may be because of a lack of specialist knowledge.

"Race hasn't been investigated. But then again, they [the IOPC and inquests] have never really been pressed to do so. There often hasn't been a push from the family [lawyer] side. And I think it's just because family lawyers in inquest cases or IOPC cases or police cases just aren't experienced in that and don't know about it."

2.2 Raising racism during an inquest viewed as 'offensive' by some coroners

There appears to be a degree of entrenched discomfort among coroners about including race in the scope of their inquiry into deaths in custody. Several lawyers interviewed had worked on cases in which a coroner had not permitted it to even be considered in the hearing. They said their questioning of whether racial stereotyping had any bearing on a person's death is often viewed by coroners as "not nice"; "rude"; "offensive" or "casting character aspersions." One lawyer described how a coroner "took umbrage" when they put forward arguments for its inclusion in an inquest of a Black man who had died after being restrained by police. This discomfort was seen as indicative of a society-wide denial of racism and its impact.

Another obstacle to race being included in the scope of inquests is a lack of knowledge about discrimination among some coroners. Although legally qualified as solicitors or barristers, most coroners do not have a discrimination law background and few work full time as coroners. Those appointed before 2013 may be doctors with even less legal expertise. Deaths following police contact are relatively rare. When confronted with such a death, they might not bring a broader understanding about the issues around race, restraint and disproportionality and key reports such as the Angiolini Review.

Lawyers said that, because racism could not be seen as a direct cause of a death, coroners may resist including it in the scope of their inquiry. Persuading them to see racism as part of the "circumstance" in which a Black person died in police custody in the absence of overt discrimination can be a hurdle and coroners frequently adopt a narrow scope to their inquiries, focusing on matters that are directly causative of death. In that light, it is easy to see how coroners might be unwilling to view a death following police contact as "permeated by race." The wide discretion of coroners in setting the scope of an inquest leaves little room to challenge a refusal to look at race.

Lawyers highlighted that there is no case law at the coronial level about how a coroner should investigate discrimination, and what factors may be relevant. However, there is a considerable amount of judicial precedent about that question in the context of employment tribunals and civil claims of discrimination. There appears to be no good reason why the principles identified in that case law should not apply equally in the coroner's court.

2.3 Weighing up whether to raise racism

In the experience of lawyers representing bereaved families, hearings involving restraint with a race, and or mental health element are hard fought and aggressively defended by the police. An inquest is supposed to be an inquisitorial process, but the lawyers' experience is that those considering a death following police restraint are the most likely to become adversarial.

Given the vital opportunity inquests present for the family to put forward their questions and hear answers, some solicitors and barristers representing families said they approach the decision about whether to raise racial discrimination at an inquest with caution. Lawyers recognised it was their job to articulate what families believe and give voice to what they want to say. But several spoke of the potential risk that raising race, with little evidence that infers discrimination, could have an adverse effect on what the family is trying to achieve. "There's a risk the jury won't like it if the family lawyer infers that race played a part. And so, there's risk in saying it because it means they might just disregard all the other good points, damaging your chance of getting the right conclusion on these."

Some lawyers described that a difficult decision had to be made to exclude the matter in certain cases.

"If you think [raising race] will ultimately detract from getting the right conclusion [on other points], that comes into your decision as to whether to explore the issue of race. Lawyers do that all the time. I've been guilty of that thinking. And there's been a number of cases where I should have run race and I didn't. And that's to my eternal shame."

However, all recognised the need for change. "It will always be distasteful unless somebody takes a position. There's no reason why this should be distasteful. This is part of an investigation, and we are entitled to look at it."

One suggestion was for juries to be given a set of directions to deal with "race myths," as happens around rape myths in sexual offences hearings to confront and acknowledge the historic and current problem of racism. Consideration is also needed of how best to phrase questions to police witnesses about racism in inquests.

There is no case law at the coronial level about how a coroner should investigate discrimination, and what factors may be relevant.

3 Decision-making by the Crown Prosecution Service

The decision to prosecute in any death following police contact differs significantly from that involving a civilian facing an allegation of murder. Such a case is referred to the Director of Public Prosecutions to be considered. This reflects both the seriousness of the incident and the ramifications for public trust.

Lawyers and INQUEST over our decades of casework are not aware of any instance where a racially aggravated charge has been brought against a police officer involved in the death of Black person.

The decision whether to bring charges or whether to bring a misconduct hearing are based upon the work of an IOPC investigation. Flaws in the IOPC investigation will inevitably undermine criminal or disciplinary processes including how racial discrimination is dealt with.

Another matter possibly militating against prosecutions for racially aggravated offences in deaths following police contact is that the CPS would stand a far higher prospect of securing a conviction for a lesser offence, although even lesser offences rarely come to trial.

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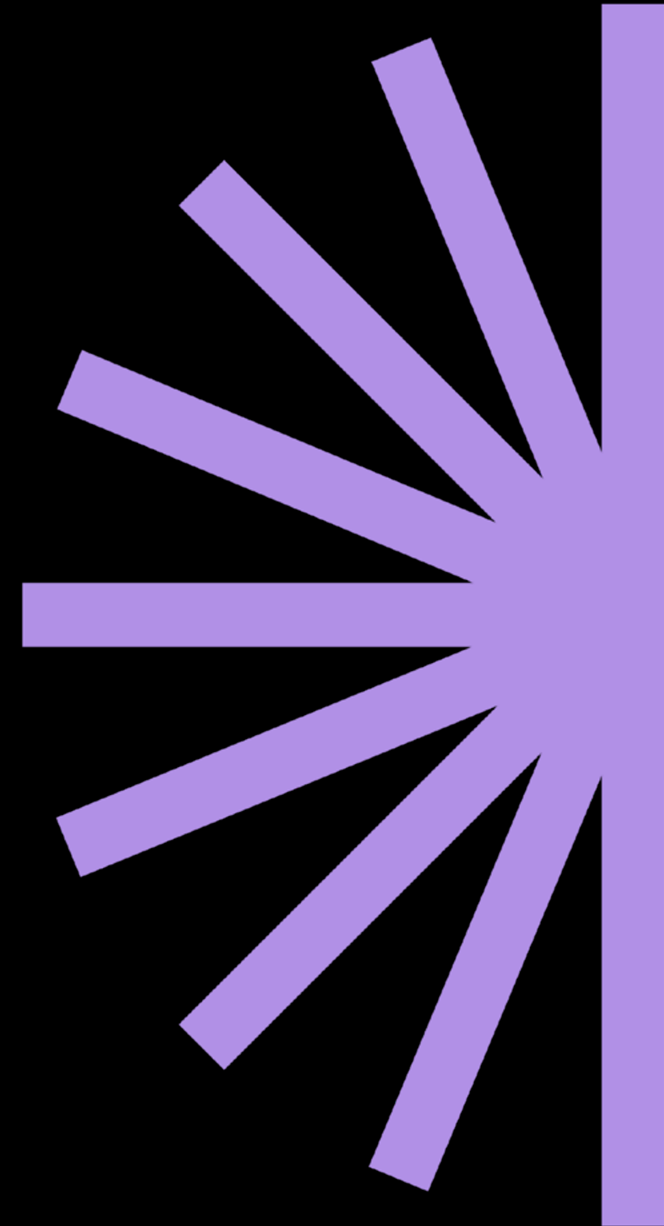
Recommendations



Recommendations

The current systems of accountability continue to fail bereaved families and do not address the causes and consequences of deaths of Black people in police custody or following police contact. Considering the evidence uncovered in this report, INQUEST recommends the following.

Post-death investigations and scrutiny

It is unacceptable that there are no available examples of IOPC investigations or coroner's inquests which gave proper consideration to the potential role of racism or discrimination in a person's death, and none that have led to any action or accountability.

Without these processes acknowledging and acting on individual and institutional racism, Black bereaved families who participate in them in good faith are being denied truth, justice and accountability.

The IOPC and the coroner's service should ensure they meaningfully consider the impact of the race/ethnicity of any Black or racialised person who dies following police contact, examining the potential role of racism or discrimination. This should be an integral and proactive part of their work to identify, and respond to, systemic issues. This in turn should be central to the work of the Crown Prosecution Service in their response to these deaths.

The IOPC should amend their guidelines and practice for handling investigations into racial discrimination to bring them into line with the way allegations of racial discrimination are approached in civil courts. This means explicitly incorporating a shifting burden of proof set out in the Equality Act 2010 and ensuring this guidance is properly applied through specific training of IOPC investigators.

The Chief Coroner should develop detailed guidance and training on how coroners should approach investigating racial discrimination in inquests to fully reflect Article 2 and the Equality Act.

In the context of Scotland these recommendations and the findings of this report more broadly should be considered by the Police Investigations and Review Commissioner, the Crown Office, and in Fatal Accident Inquiry processes.

Black bereaved families are being denied truth, justice and accountability

Inspectorate and monitoring bodies

Consideration of the impact of race and racism on the treatment of people in police custody and contact should be central to the continued work of monitoring and inspectorate bodies such as the UK National Preventive Mechanism, HM inspectorate of Constabulary and Fire and Rescue Services and Independent Custody Visitors. While data and monitoring are important, any reporting should also include analysis and recommendations which lead to measurable action

The treatment of Black people by police

Urgent action is required to prevent all deaths in and following police contact. There must be specific focus on addressing institutional racism, which should include action from police and broader public services to address the treatment of Black people who face specific types of racist, inhumane and violent treatment and disproportionately die in or following police custody and contact as a result.

We call on the UK Government, Home Office and national police forces to make a time-bound public commitment to end the deaths, disproportionate use of force, and broader ill treatment, of Black people in police contact. This commitment should include the following recommendations around restraint and mental health.

Restraint

The Angiolini review (2017) recommended that national policing policy, practice and training recognise that all restraint can cause death, and that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life-threatening risk.

More than five years on, such changes are not yet reflected on the ground. The restraint-related deaths and data in this report evidence the disproportionate impact this systemic failure has on Black people, especially those with mental ill health.

We call on the government to implement the unfulfilled recommendations of the Angiolini Review (2017), with a particular focus on recommendations relating to the use of force and restraint.

Mental Health

The issues of discrimination around race and mental health intersect, as evidenced in the deaths detailed in this report and many other cases recently and historically. Police use of force is too often the first response to Black people in mental health crisis, rather than the de-escalation, care and compassion required.

Mental ill health is a public health issue, not a criminal justice one. This includes mental health crises relating to or induced by intoxication. We must urgently move away from police being first responders to people in mental health crisis. Past efforts at training police on mental health have failed to reduce the number of deaths.

In the short term, where police do become involved in responding to a mental health crisis through absolute

necessity, national policy and practice must ensure that de-escalation and care is the focus. Every effort must be made to avoid use of force and restraint, and minimise police contact.

In the long term, the UK Government should urgently review national and international evidence on alternatives to policing in responding to people in mental health crisis, with the aim of creating nationally available systems which put community services and specialist healthcare practitioners at the centre of crisis responses, without police. Improvements must also be made to NHS and community services to ensure they can prevent people reaching crisis point, and centre care and compassion not criminalisation, use of force and detention.

Data

Black people are dying disproportionately following police use of force. But there is no public dataset showing the breakdown of all deaths following police restraint by ethnicity, despite this being a key recommendation of the Angiolini review over five years ago. Instead, the IOPC reports the data within two broad categories, which obscures the extent of this issue.

To provide improved transparency, and to facilitate better analysis of the relationship between race and restraint related deaths, we call on the IOPC to monitor and publish data on restraint-related deaths both in police custody and other deaths following police contact, disaggregated by ethnicity and other protected characteristics.

Duty of Candour

The defensiveness and lack of openness of police forces and officers involved in post death investigations has been evidenced clearly in this report and elsewhere.

In the short term, the IOPC should invoke the 'duty of cooperation' to ensure police officers and forces comply with its investigations. Coroners should consider taking more robust action where officers do not fully participate or are not open or honest during inquest hearings.

In the long term, in order to ensure honesty and proactive cooperation of public authorities and representatives with official investigations and inquiries, the government must implement Hillsborough Law to create a new legal duty of candour for police and other agencies.

Access to justice

More work must be done across services to ensure that bereaved families of victims of deaths in police custody receive adequate practical, emotional and financial support to engage in the complex inquest and investigation system.

The Government, coroners service and IOPC should enact the outstanding recommendations of the Angiolini review (2017) around family support and the coronial system. These include recommendations on access and support for attending inquests and participating in investigations, improved advice and support, and the need for a National Coroner Service with specialist Article 2 coroners.

National Oversight Mechanism

When post-death processes work as they should, recommendations arising from inquests, investigations and inquiries are invaluable. They are intended to prevent future deaths, but there is currently no oversight of these recommendations nationally and no mechanism to follow them up.

Therefore, the government must establish a new and independent body tasked with the duty to collate, analyse and monitor learning and implementation arising out of post-death investigations and inquiries. The monitoring and implementation of recommendations on racism and discrimination must be central to its work. The mechanism should provide a role for bereaved families and community groups to voice concerns and provide a mandate for its work.

Transformative Social Change

For 40 years, INQUEST has campaigned on these issues. It is clear from our work that real and sustainable change which enables social and racial justice must be systemic and transformative.

To end the heightened criminalisation and deaths of Black people in contact with the police, we must decrease reliance on policing and investment in the criminal justice system. Public funding and policy must prioritise welfare, health, housing, education, youth services and social care. This holistic approach would help address the root causes of crime and violence in our society.

Unlocking the truth for 40 years

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Obtained in April 2024 from:https://www.inquest.org.uk/i-cant-breathe-race-death-british-policing