Thursday, 27 June 2024.

(10.03 am)

LORD BRACADALE: Good morning. I wish to make a short statement in order to put a matter on public record.

The next witness is Deborah Coles. Core participants and others will recall that at the preliminary hearing when I introduced my assessor Raju Bhatt, I mentioned that as a solicitor he had over many years represented families who had lost members through death in custody.

In addition, he had been a member of various review groups and panels. Given the nature of his involvement in that type of work, Mr Bhatt knows Deborah Coles and has had a professional relationship with her and Inquest over the years.

Could we now have the witness in?

Good morning, Ms Coles?

A. Good morning.

LORD BRACADALE: Would you raise your hands and say the words of the oath.

A. Sorry, I was going to affirm, please.

LORD BRACADALE: You wish to affirm, certainly. Will you say these words after me.

Evidence of DEBORAH COLES (AFFIRMED)

LORD BRACADALE: Ms Grahame.

MS GRAHAME: Thank you.

Examination-in-chief by MS GRAHAME

MS GRAHAME: Good morning, Ms Coles. You are Deborah Coles?

A. I am.

Q. May I ask what age you are?

A. 61.

Q. And you are the executive director of Inquest based in London, as I understand it?

A. Yes, that's correct.

Q. And you have held that particular post in Inquest since around February 2017; is that right?

A. Yes, prior to that I was codirector and prior to that I was somewhat bizarrely named joint organiser.

Q. Right. No doubt a very busy job?

A. Yes, indeed.

Q. And I understand you have worked for Inquest since 1989; is that correct?

A. Correct.

Q. And they are a charity?

A. Yes.

Q. Now, my understanding, and please correct me if I'm wrong, is that there is no similar organisation in Scotland to Inquest that families of bereaved people

could attend or seek advice from and actually in the UK Inquest is unique in the role that they play?

A. That's correct.

Q. Before I ask you about your contact with the inquiry and your statements and your work with Inquest and involvement with the family of Mr Bayoh, am I right in saying that you would like to say just a few words at the outset and you have sought the permission of the Chair to do so?

A. That's right.

Q. Would you like to take an opportunity now to say something?

A. Yes. As everybody is aware, I have known the family of Sheku since his passing, but I wanted to take this opportunity to pay my respect and honour the family for their courage and commitment to finding out the truth about how Sheku died.

I know from my work the real emotional and physical toll that this plays on families, not least when a process lasts many, many years and and how it disrupts family life, careers, and the fact that they have attended this Inquiry every single day of this hearing I think is a real testament to their love for Sheku and I felt it was very important I had the chance to share that.

Q. Thank you very much.

Can I begin, first of all, by looking at your contact with the inquiry. I'm aware that you have attended some previous hearings and watched some evidence and you may then be aware that there is a blue folder sitting in front of you on the desk.

A. Yes.

Q. And you may have heard me speak to other witnesses about the blue folder.

Now, you have provided two statements to the Inquiry, which I'm going to come onto in a moment, but we're aware that some witnesses prefer to have a hard copy in front of them.

A. Yes.

Q. And if you're one of those witnesses then, please, feel free to use those hard copies in any way that you wish to do so. If you want to scribble on them, if you want to look through them, they're yours and for your use during your evidence today.

A. Thank you.

Q. As you will have seen with previous hearings, when I have a part of your statement I would like to refer you to, it will come up on the screen in front of you and if there's anything that you think I should also be looking at in addition, please let me know what the paragraph

number is and we'll have it on here. If we don't have a document that you would find helpful, we will try and get it at the next break or we'll try and get it over lunch.

A. Yes.

Q. Can we look first of all at the first statement you gave to the Inquiry. I think initially there was what we are calling a Rule 8 request which was a written request from the Inquiry for you to prepare a written response to the inquiry. I will call that your first statement, if I may, and the request is SBPI 00592, and we can see that on the screen. That was the list of questions that you were sent.

A. Hm-hmm.

Q. And then your response is SBPI 00366 and we'll see that coming up on the screen. So that was your first response there in light of the response request from the Inquiry.

And if we look at this, first of all, you will see on the final page that it was signed on 14 September 2023.

A. Yes.

Q. And we look at the last page. There we are. Now, this is the final page, but am I right in saying every page was signed by you?

A. Yes.
Q. Now, we have a redacted copy, so your signature isn't on screen, but your own copy should have your signature?
A. Yes, indeed, it does.
Q. And the date of signature is 14 September 2023.
A. Yes.
Q. Now, that's 40 pages long and if we go back to the top, I'll just summarise that the format of this is that we identified a number of themes that we were particularly interested in asking you about and you've gone through those commenting.
A. Yes.
Q. You've added in quotations from families that you've dealt with over the years. I think you have a section for each topic called the "The Family Voice".
A. Hm-hmm.
Q. And are these actual quotations from families you have dealt with in Inquest over the years?
A. Yes, and they will largely have come from family listening days that we will have been commissioned to hold on behalf of different organisations or different government commissioned reviews, for example, the review conducted by Lady Angiolini.
Q. Now, we've heard from Lady Angiolini last week and she told us about the family listening days that were

conducted as part of one of her reports. Could you tell us just a little bit about how you organise those and what the format is?

A. Yes, I mean in the context of the Angiolini Review we were commissioned by the Home Office -- well, as part of the review, to hold family listening days. And these are days that have been designed to bring together a group of bereaved families to share their experiences of the investigation and inquest processes that follow deaths and if I talk specifically about the Angiolini Review, that would have been deaths in police custody and following police contact. So those families are brought together and then they are taken through the journey pre police contact, post death, and then through the investigation systems and then either the inquest or in the unusual event there's any other legal action.

And the whole purpose behind them is to hear direct family testimony about their experiences, but also families' ideas for change, how processes could be improved, any examples of good practice. So they are very much family testimony and then they are -- those days are written up into reports which are then made public and for the Angiolini Review I think that the two days we held very much informed the recommendations that she made, particularly around family experience,

treatment of families, but also about the investigation systems.

Q. And so in the Angiolini Report I think, which is the Death in Custody Report from 2017, the family listening days formed -- the record of that formed an appendix to her report?

A. Correct.

Q. And we've heard about that and for you your statement, which we see on the screen, "The Family Voices", with quotation marks, that will contain similar quotations and remarks made by families who have been in this situation?

A. Yes. There will also be quotes from a family listening day that we ran for what was then the Independent Police Complaints Commission. So what I tried to do in the statement is draw out quotations from families that I thought would assist in documenting their experiences and their suggestions for change.

Q. Whatever the topic we've asked you to give your statement on --

A. Yes.

Q. -- you've sought statements and quotations from family members and the Chair can have regard to that as well?

A. Yes.

Q. Thank you. And then you've also in this statement given

us a section called "Best Practice" and I'm interested in the main aim that you had in providing that section?

A. I suppose when I was considering how this statement could best assist the Inquiry, it was to draw on my experience of this work and my involvement in other reviews and inquiries and to try and ensure that I used that expertise to help inform this Inquiry consider what recommendations the Chair might like to make to, I suppose, draw on what we know has gone wrong in the past, but also what we know can best work, particularly around the treatment of bereaved people and also for more effective investigations and accountability.

Q. The best practice section will reflect the learning from the families by Inquest and will reflect possible changes that could be implemented to assist families, make life easier for them, to provide them with support, minimise some of the issues that they've had?

A. Yes, I mean I think I would say not just from families and their testimony, but also Inquest's long-standing work with families and our overview of the investigation and Inquest and indeed, more recently, observations of fatal accident inquiries in Scotland so it's a combination of that experience.

Q. And Inquest, as I understand it, are an organisation that has 40 years' experience of these matters, is that

you?

A. That's true, yes.

Q. And can I ask you to confirm that the contents of this statement that we see on the screen are true and you've endeavored to be as accurate as possible in the contents that you've provided for the Chair?

A. Absolutely. Just one thing I have noticed is that this statement was signed in September 2023 when I was still a member of the cross-government sponsored Independent Advisory Panel on Deaths in Custody and my third term of office on that panel concluded at the end of last year, so I am no longer on that, just for accuracy's sake.

Q. We'll come on to that in a moment, but that was the position when it was signed?

A. Yes.

Q. And can I confirm with you that you understand that this statement may form part of the evidence available to the Chair to consider and it will be published on the Inquiry's website at the conclusion of your evidence?

A. Yes.

Q. Thank you. Can I look at your second statement, please. Now, the request was SBPI 00591 and that was sent to you. There we are. That's the questions that were sent, and then the actual second statement, if I can

call it that, or the response to the Rule 8 request is SBPI 00607.

And you'll see that this is headed up "Expert Witnesses Statement, Deborah Coles," and if we move down a page, it was taken by the Inquiry team on 25 and 30 April this year. Do you recognise this statement?

A. Yes.

Q. Okay. And if we look at the last page, it's 56 pages long, and, again, we have a redacted version so your signature is not appearing on the screen, but you have a hard copy in the folder and that was signed by you on 23 May 2024.

And if we could look at the final paragraph, 177, this says:

"I believe the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website."

A. Yes.

Q. And you understood that to be the case when you signed it?

A. Yes.

Q. Thank you.

Can I turn to your work now with Inquest, please. We've -- you've explained it's a charity. Please

correct me if I'm wrong, are Inquest the only charity providing expertise on State-related deaths under investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians?

A. Yes.

Q. So you're providing advice and support, if required, to those individuals or organisations?

A. Yes. So we have a casework team who work directly with families after deaths in custody and detention, so that includes police, prison, mental health settings, immigration settings, learning disability settings, as well as we're involved with some of the families who were bereaved after the Grenfell Tower fire. And so that's direct casework support. And then we also have -- we do policy and campaigning work for change.

Q. Right, thank you.

Can we look at SBPI 00366, and this is your first statement. Now, if we could look at paragraphs 7, 8 and 9, let's start with 7 and I think you gave us a summary of the work that Inquest do. 7:

"We work with bereaved families from the outset, supporting them through post-death investigation processes. We coordinate a national network of over 400 lawyers, the Inquest Lawyers Group (ILG), who providing specialist legal representation for bereaved families.

We hold regular roundtable meetings between ILG members and investigative bodies to inform discussions around best practice and raise issues of concern. This includes regular meetings with investigation bodies and that includes the Prisons and Probation Ombudsman, the Independent Office of Police Conduct and other relevant stakeholders, including His Majesty's Inspectorate of Prisons, the Chief Coroner and the Crown Prosecution Service."

And is that part of what you described as your direct casework and support?

A. Yes, the direct casework and support obviously for bereaved families, but then the policy work we do involving the regular meetings with the organisations.

Q. With the organisations, thank you. And paragraph 8, if we can just move down the page:

"Our specialist casework service gives Inquest a unique perspective on the operation of the post-death investigative system. This overview enables us to identify systematic issues arising from deaths and the way they are investigated and understand how recommendations arising from individual deaths are followed up and changes made, both at a local and national level."

And we know that you're based in London?

A. Yes.
Q. And do you work primarily in England and Wales?
A. Primarily, yes.
Q. But you have had some experience of work or cases involving Scotland?
A. Yes.
Q. And you've said this is a unique perspective. As at today's date, are you aware of any other charity that fulfills this role that Inquest does?
A. No.
Q. None. And paragraph 9:

"In addition, our focus on deaths in custody and detention means Inquest holds knowledge on the operation of detention systems. Our knowledge and experience is extensive, detailed and evidence-based going back four decades. Inquest's policy work and casework situates deaths in their broader social and political context. For example, we have carried out thematic areas of work on deaths in women's prisons, deaths of children and young people, deaths of black and racialised people in prison and following police contact, deaths in immigration detention, and deaths in mental health settings. Our research shows that State-related deaths are not just isolated individual tragedies, but in part related to historic and systemic issues, such as

structural racism, discrimination and other concerns such as inequality and poverty."

In this inquiry we're primarily interested in the death of a black man, as you know, Mr Bayoh, who died on 3 May 2015 and that was following police contact. You have talked here about thematic areas of work in relation to deaths of black people following police contact. Can you explain what you mean by "thematic work"?

A. Yes, I mean I think one of the benefits of an organisation not only going back four decades, but that has the day-to-day work with families is that we are able to both look back and looked at present day, so that has enabled us to identify through our casework, our statistical monitoring trends and patterns. And so from when I started in really doing this work in the early nineties, we were aware of a pattern of deaths of black people, particularly black men, who were dying after being restrained by police officers and so that has always remained an organisational priority and has enabled us to conduct thematic work and by that I mean using the evidence that we've gleaned from the investigations and primarily inquests in order to identify systematic issues that came out of those individual cases.

And I think the important point there is the point that I make about the fact that of course for families these are individual tragedies, but as an organisation we're able to look at them in a broader context and show that they are systematic, that there is an ongoing pattern and a pattern that has been going back decades.

Q. Thank you. And we'll come on to those patterns later today.

A. Yes.

Q. Can I say from reading this paragraph, is it fair to say that you work with families of those who have died who are of all races or is it simply just black people.

A. Oh, no. I mean absolutely our work cuts across race, gender, disability. I mean it's when you consider the nature of the work that we do, particularly on deaths in custody and detention, it affects all communities, but I think it's important probably to say that some of the concerns we have raise particular concerns about the treatment of people from particular communities, so the relevance of race, the relevance of class and gender is felt in our work and in the thematic areas that we have chosen to delve into more deeply.

Q. Thank you. I think obviously our interest primarily is in relation to the death of a black man.

A. Yes.

Q. And so it will be against that context that I ask you questions today.
A. Absolutely, yes.
Q. Now, you mentioned a moment ago that you had been a member of the cross-government sponsored Independent Advisory Panel for Deaths in Custody. That's quite a mouthful. Did I get that correct?
A. It is, the IAP.
Q. Could you help me understand the work of that cross party?
A. Yes, so this was a public appointment that had to be approved by the Secretary State for Justice, of which there have been many in the period that I was on the IAP, but effectively the role of that panel was to give advice to ministers, particularly concerning, you know, the prevention of deaths in custody so that cut across deaths in police, prison and mental health detention.

And we were a panel that met regularly, carried out particular pieces of research, would give evidence to conferences and, as part of that, there were a particular review -- I mean albeit this is about prison, but Lord Harris, who was one of the chairs of the IAP, conducted a review of deaths of children and young people in prison, so I was involved in that review. But effectively it was to try and take forward some of the

issues raised by deaths in custody and the panel members were from a broad rang of professions, pathologist, academics, lawyers and myself.

And so I think most relevant probably to this Inquiry is that obviously deaths in police custody and following police contact was one of the thematic areas that the panel looked at.

Q. And was that in your capacity as now the director of Inquest?

A. Yes. I mean I was director of Inquest, but it was a public appointment so it was something I did as well as my --

Q. So it was actually a public appointment of you as an individual?

A. Yes.

Q. Now I understand in addition to information that you have given the Chair in your statements, that you may also have a CV which provides more detail?

A. Yes, I have a CV which I can make available, absolutely.

Q. I wondered if you would be willing to make that available to the Chair?

A. Of course, yes.

Q. Thank you very much. The Inquiry team will be in touch with you in that regard.

Now, as well as the cross-party work you have been

telling us about, you have also mentioned the Death in Custody Report by Lady Angiolini, as she now is.

A. Yes.

Q. And you've told us about the listening days. I also noted in your statement 607 at paragraph 57 that Inquest have also worked in relation to matters that come before the United Nations?

A. Yes.

Q. And I think here you've talked about submissions that Inquest have made to the UN on data in deaths in custody?

A. Hm-hmm.

Q. And I think they're listed here in this paragraph. There is a submission on systematic racism in December 2002, in relation to independent expert mechanism to advance racial justice and equality and that was in the context of law enforcement in May 2022 and the Inquest submission to the United Nations Special Rapporteur on extrajudicial, summary and arbitrary executions on the investigation documentation and prevention of deaths in custody in the criminal justice context from March of last year.

Can you tell us a little about these submissions?

A. Yes, and in fact, just looking at that, it reminds me and I can't remember if it's in any of my statements

that previously we have also given evidence to the United Nations Third Committee, which is the committee on the elimination of racial discrimination and that one of the early submissions we made was back in the early nineties and it was particularly around the fact that there was no available data on deaths in police custody, disaggregated by race and ethnicity. I mean that's quite an old report, but it's relevant in this context.

And we have had a long-standing period of engagement with the United Nations and I have previously given evidence on concerns around deaths of black people in and following police contact. And so we keep a watching brief on when they were doing various inquiries and reviews and try, where capacity allows, to inform those reviews. And this section particularly refers to, I think, the question I was asked about data and the importance of good quality data.

Q. Thank you. And although you said the submissions, the evidence you provided in the nineties was old in relation to data, is that something that you consider the Chair might find useful?

A. Yes, I'll dig that out.

Q. Would you be able to provide us with that?

A. Yes.

Q. Thank you. Certainly we have asked a number of

witnesses questions about data and issues with data and it may be of interest to the Chair to see what you were saying in the nineties.

Can I move on then, please, and ask you about your prior involvement with the family?

A. Yes.

Q. I think it's correct to say that in 2015, for the family of Mr Bayoh, if they were seeking support or guidance of any description, there were two options. One to instruct their own solicitor, but one who would be willing to give pro bono advice, because as I understand the position there's no legal aid provided?

A. Yes.

Q. And the other would be to come to and make contact with Inquest in London, because at that stage there was no charity available in Scotland. And I think you've explained that was certainly the position in regard to other charities today. Does that remain the position today for families who are looking for support in a situation such as this for a bereaved family? Do those remain the two options, either to come Inquest or to seek a lawyer who would do it pro bono?

A. Yes, but it also -- I suppose it also begs the question of whether or not those families have even been informed of their rights to seek legal representation and I think

that's one of my concerns is that that complete gap in advice and support, you know, in those very early days about what families' legal rights are in these processes and certainly in Scotland, I'm very conscious that there is an absence of any organisation like ours. And to be perfectly honest, it's a question of luck as to whether or not families may find out about our organisation or not.

A lot of families in the England and Wales context will just Google "Inquest" because they might have been told that at some point there will be an inquest and of course we pop up, but that I think is something that Lady Angiolini made very clear in her report that, you know, when something catastrophic happens that a family of course have never experienced before, the thing that they need is, you know, proper advice and support about what the processes are going to be and it's not a question, as she very well put it I think in her review, it's not a question of tea and sympathy, it's about practical advice and information about your rights in the process and what is going to happen.

So it's fair to say that at the moment it is really lacking in the Scottish jurisdiction I think.

Q. In England and Wales, is there a body or an organisation that is under an obligation to advise families in this

situation that they can seek legal advice?

A. Did you say obligation?

Q. Is there an organisation with an obligation to advise families along those lines?

A. No, not an obligation, but I mean I think best practice it is assumed that those bodies who are conducting investigations should tell families what their rights in the process are. And now I think, you know, following a lot of work by families and by Inquest, there are organisations who have leaflets that take them through the process, but also will give information on organisations that can help. So obviously Inquest, as you have already said, is unique in the sense we, you know, that's what we're there for, but also other bereavement organisations or organisations that might help with some of the post-death processes that families have to go through.

Q. Right. And are you aware of any organisation that has not necessarily an obligation, given what you said, but a practice of providing families in that situation with that advice?

A. In Scotland?

Q. In Scotland.

A. No, and I mean when I was doing my kind of scoping work looking at the situation in Scotland, I conducted some

desk research and found it extremely difficult to find out any information and in fact you just kind of -- the delights of kind of Google searches is you find yourself going from website to website, but ending up nowhere. So I felt, and I think I addressed this in my first statement in terms of best practice, what I felt could be done to alleviate that information deficit really I would call it.

Q. Thank you. Sticking with the meetings you have had with the family, you have addressed this in both of your statements --

A. Hm-hmm.

Q. -- in some detail. Let's look at those for the moment. The first one, 366, if we could look at paragraph 12, and you explained that you were contacted by Aamer Anwar, solicitor, a few days after the death of Sheku Bayoh:

"... who was aware of my work at Inquest on other restraint-related deaths following police contact. We have over 400 lawyers in our Inquest lawyers group who benefit from our extensive resources and information and Aamer joined this network in 2015."

And that was the year Mr Bayoh died?

A. Yes.

Q. "In the absence of any similar organisation in Scotland

with expertise in this area and with no funding available for legal representation, I supplied as much information and resources on restraint-related deaths and Article 2 investigations to assist the legal team."

A. Correct.

Q. "In the first instance, I advised on the importance of a second postmortem and the expertise in this area of pathologist Nat Carey and Dr Maurice Lipsedge."

And we have had the benefit of both those gentlemen's evidence. And at 13 you say:

"I attended several meetings with family members to share my experience and offer ongoing support through what I knew would be a protracted and complex legal process. I attended meetings with the family's counsel and shared a variety of resources to assist them in their background research."

So was this a number of meetings where you met with the lawyers, the legal representatives, solicitor and counsel for the family?

A. Yes.

Q. And was that part of the support that Inquest give to families who are bereaved?

A. Yes, and I mean I think in particular Aamer Anwar contacted me because he was aware of the fact that Inquest had worked on a series of restraint-related

deaths previously and I was very keen to share my advice and expertise at that early stage, particularly because I was conscious about the importance of trying to get the information and things done properly from the outset to avoid any potential problems moving forward and certainly the issue of a second postmortem and ensuring that there was a pathologist with experience of conducting postmortems into restraint-related deaths and I felt that that was really, really critical in those early stages.

Q. Thank you. And then do we see at paragraph 14 that you also mention attending a meeting with the PIRC?

A. Yes.

Q. The Lord Advocate, Frank Mulholland, the Crown Office and James Wolffe, the second Lord Advocate involved:

"All of whom welcomed meeting me because of my knowledge in this area. It became clear to me that there were real concerns with the rigour and independence of the PIRC investigation and the very limited scope of any subsequent fatal accident inquiry. I worked with the family and their legal team to develop arguments for why the seriousness and complexity of Sheku Bayoh's death warranted a statutorily public inquiry with a broad term of reference. This involved meetings with the then Justice Secretary Hamza Yusuf and

First Minister Nicola Sturgeon. I have also shared my experience on restraint-related deaths and their broader context to public meetings and the media."

So you refer to a number of meetings in this paragraph --

A. Yes.

Q. -- with a number of different individuals or organisations. And is this the type of support that you provide in Inquest to families?

A. Yes, I mean it's obviously all dependent on capacity and resources but, you know, I was very conscious that this was, you know, an extremely important death that needed robust scrutiny and given that I had started doing a wee bit of kind of scoping within Scotland, it felt important to put in that time and resource. But clearly, and I think it's important to say, I am based in London and being the CEO of an organisation involves a lot of other work, so my involvement had to be balanced against the demands of the organisation.

Q. Now, I think you have mentioned scoping in Scotland.

A. Yes.

Q. And you mention this in one of your statements.

A. Hm-hmm.

Q. Could you explain to the Chair a little about that work that you were doing in Scotland?

A. Yes, I mean initially Inquest and I was contacted by the Scottish Government who were conducting a review of how deaths in mental health settings were investigated and I was asked to come and give evidence. I believe it was the section -- I think it's called the Section 37 Review. I'm sure I'll be corrected. It's in my statement.

And I became and this -- the Mental Welfare Commission were also at that time conducting some research and looking at how they, as the Commission, were working with families and so I was invited to come up and, you know, share my expertise, you know, which I indeed did. And through that I became more interested in how the investigation and FAI process worked and around that time, not only was I contacted by Aamer Anwar, we were also contacted by the family of Katie Allan, who was a 21-year-old young woman who died in Polmont Young Offenders' Institution and she contacted Inquest so I was able to refer her to Aamer Anwar.

And so from a kind of initial, you know, focus I managed to get some funding to do some more scoping looking at the different processes operating in Scotland and, in particular, looking at families' experiences and also families' access to justice, which was how I was

able to, you know, make my observations within my statements about, you know, the lack of any similar organisation, but also the difficulty that families have in trying to find out what their legal rights are and their ability to properly, effectively participate in the processes that follow a death.

Q. And you have mentioned funding, as a charity, does Inquest rely on funding being provided?

A. Yes, we don't take any State funding, because our independence is important, so we are funded entirely by trusts and foundations and also donations. That being said obviously, you know, when I was appointed as the special advisor to Lady Elish Angiolini, I was paid from the review for my time and my expertise on that review, but we are a charity and so we are funded entirely by trusts and foundations and that is a challenging role because fund-raising is not easy, not least at the moment.

Q. Thank you. And then if we could move on to your second statement, 607 and if we could look at paragraph 3, first of all. I think --

A. Yes.

Q. -- you were referred to -- we have heard evidence from Lindsey Miller, she's within Crown Office, and she mentioned three meetings in Crown Office between the

Crown Office and Aamer Anwar, at which you were present. That was July 2015, 15 October 2015 and October 2018. And does that accord with your memory of --

A. Yes.

Q. -- the meetings?

A. Yes.

Q. And then if we could look at paragraph 14, and you provide some further detail about these meetings:

"I know there was a meeting I attended with Frank Mulholland... "

A. Yes.

Q. "... when he was Lord Advocate. I thought that was an extremely productive and positive meeting. I distinctly remember being surprised and really welcoming the openness and seriousness with which the Lord Advocate listened to what we had to say. I had the opportunity to talk about my experience of similar deaths in England and Wales and was listened to really carefully. At that time, there were already real concerns about the way in which the investigation was being carried out. My understanding of the evidence we've heard at this inquiry is that at that time that Lord Mulholland was Lord Advocate, the investigation was being carried out by PIRC."

Does that accord --

A. Yes.
Q. -- with your recollection?
A. Yes.
Q. "My recollection is that there was a commitment from him, Frank Mulholland, to ensure that this was a very far-reaching inquiry. The very fact that we had an audience with the Lord Advocate at such an early stage to me gave me quite a lot confidence and made me feel quite reassured that somebody of such legal seniority was taking on what we all had to say with seriousness. The very fact that he met with the family that was extremely important and good practice."
And I'm interested in your comment about how positive -- you describe this meeting in a positive way and you describe it as extremely important and good practice?
A. Yes.
Q. Can you help the Chair understand how this very positive approach, what impact that had on the family at the time?
A. I mean I think the family felt listened to, I felt that they had trust and confidence in his commitment as Lord Advocate to ensuring that this was a robust and, you know, far-reaching inquiry and I certainly felt that as well. You know, we -- I recall we sat around the

table and we were given enough time to actually talk through what all the different concerns were. I felt that I was treated with real respect about, you know, my experience, that I was listened to, and I think we all came away thinking, well, this made us all feel that perhaps there was going to be the investigation that such a serious death warranted.

Q. And you've talked about being aware of concerns or you describe them as already real concerns --

A. Yes.

Q. -- about the PIRC investigation, but you've also said the family maintained trust and confidence in the process itself?

A. Well, I think Frank Mulholland was extremely open and listened really carefully and gave the family a real opportunity to talk through what their concerns were. And, you know, for somebody that, you know, was coming from the England and Wales jurisdiction to have an audience with the Lord Advocate, for me felt extremely positive and gave us all reassurance, but sadly that was not then subsequently met.

Q. Can we look at the next paragraph where you describe the change:

"I'm asked if I have any further comments to make about at the meetings I attended with the Crown Office

or Lords Advocate. Much later down the line, on 23 October 2018, my notes say I was at a follow-up meeting with the next Lord Advocate, James Wolffe, and the family and their lawyers. My role in these meetings would always be to listen, but also to add my thoughts where I felt I had something useful to say. It was my expertise and understanding of investigations into these deaths over three decades that added value to those meetings, because I could compare my experience of similar deaths and how investigations were carried out to encourage best practice and to try to avoid a repeat of investigations I have been involved in that have gone wrong. There was enough good practice to be able to help inform the approach that the relevant authorities were taking. As the meetings went along, it was becoming increasingly clear that this was not going to be the robust independent investigation that we had hoped for and was committed to following the meeting with the previous Lord Advocate Frank Mulholland."

And I'm interested in the final of this paragraph 15:

"It became increasingly clear that this was not going to be the robust independent investigation that we had hoped for."

Can you explain to the Chair why there was this

change, what happened?

A. I mean I think from recollection there was certainly a lot of defensiveness from the PIRC and from the Crown Office in response to the concerns that were being raised. I had said very early on at one of the first PIRC meetings the importance of ensuring that there was, you know, a proper pathologist with expertise appointed and was then extremely concerned to hear that the instruction had been to Steven Karch. And I was very clear in, you know, what I said about that and I had already explained that we had concerns about his approach to restraint-related deaths, particularly about he as a proponent of excited delirium.

There was also I think I was told that I should -- when I was raising concerns, I was told that I should be reassured that the PIRC were taking advice from what was then the Independent Police Complaints Commission, now the IOPC, and, to be frank, that didn't reassure, but rather concerned me, because, you know, we had at that time ongoing discussions both as Inquest, but also with our Inquest lawyers group, about concerns with the way in which the IPCC were conducting investigations at that time.

And what I had always tried to do in any of these meetings was to try and use my experience to help avoid

the mistakes that I had seen from previous cases in the past. That was my role, you know. I mean, you know, to be clear, I'm not a lawyer, but I do have considerable experience in these investigations going back many, many years. So I was there to try and just assist and, you know, and I believe I was professional in doing that, but I think increasingly what I felt was the legitimate concerns that were being raised by the family, by their lawyer, and by myself were just met with a lack of interest, a lack of seriousness and lack of defensiveness and I think that characterised my experience moving forward, which was in such sharp contrast to what we had experienced with Frank Mulholland.

You know, that was such a good -- it was such a good meeting and it did inspire confidence and so therefore there was a real disconnect between that and the kind of aspirations that he had for the investigations and then what subsequently followed. And of course it was then not helped by some of the kind of misinformation that was then, you know, appearing in the media.

Q. Well, you've described how the differences in the way the meetings were handled between Frank Mulholland and James Wolffe had an impact?

A. Yes.

Q. Looking back now, can you think of any ways where that second meeting or the meeting you had with James Wolffe could have been better handled to maintain what had been a very positive approach at the outset?

A. Well, I mean I think -- I think by that time, I mean if I'm recalling the right meeting, if I kind of remember correctly, there was just -- there was just so much evidence that that robust investigation that we had all hoped was simply not -- was simply not happening. And I would say what, you know, if -- I think if we had all been listened to and I think if, you know, expertise had been sought from the right people, and I think it's fair to say that the PIRC were given ample information about who they could consult with, who they could instruct, I think had that -- had they approached meeting --

I mean, for example, at one of the meetings I was told, oh, well, you know, the fatal accident inquiry, that will be the opportunity to, you know, to find out more or to explore these areas in more detail. And that to me suggested that they had already decided that this was not going to be an investigation that resulted in any criminal prosecution. It was almost that the decision had been made that this would be an investigation and then it would end up being a fatal accident inquiry. And I think that demonstrated to me

almost that preconceptions about the fact that this was an investigation that was going to be carried out and then it would end up in a fatal accident inquiry.

And that kind of institution unwillingness to consider whether or not the evidence that they were going to -- that they were going to find out would result in, you know, potential wrongdoing or criminality by police officers and, you know, I'm afraid to say that that was exactly some of the challenges that we were having at the time with the IPCC in terms of that unwillingness to robustly explore and investigate properly.

Q. At the time you met with James Wolffe, the then Lord Advocate, was that when the investigation was still ongoing, because I know you mention one date but that's --

A. Yes.

Q. We've heard evidence that was after the no pro decision had been taken?

A. Yes.

Q. I'm just wondering if you could perhaps be mistaken about that?

A. Maybe it was the second of those meetings.

Q. At the time you met with James Wolffe, was the investigation still ongoing?

A. Still ongoing the first time, yes.
Q. Thank you. Now, you mentioned if they had taken advice from the right people, who would the right people have been?
A. Well, I mean I said at the -- I think I believe that at the first meeting I talked about the importance of the postmortem medical evidence, so I specifically mentioned Nat Cary and Maurice Lipsedge, because we had worked with them previously and I knew that they had a particular understanding and expertise in restraint-related deaths.

You know, likewise, we had such a wealth of information about inquests and investigations that I was able to talk about individual cases and also direct them to available information, but as I say my -- the impression that I was given was that, you know, they had already set in mind the direction they were going, they were seeking advice from the IPCC, and then they instructed Steven Karch and, you know, I did express my concerns.

I also talked about, of course, the importance of Article 2, the right to life, and how it was absolutely vital that Sheku's family were able to effectively participate in the investigation and that's not just a question, you know, as I said before, this isn't about

being nice to a family, it's about their legal rights to play a meaningful part and to have their concerns addressed.

Q. Thank you. Now you have mentioned Steven Karch a couple of times today.

A. Yes.

Q. And we have heard evidence in relation to Mr Karch and we have an Inquiry statement from him. I'm interested in when you expressed your concerns about Steven Karch to Crown Office, do you remember? Was it at the first meeting or at subsequent meetings?

A. I believe it was with -- I don't think it was the Crown Office, I think it was the PIRC.

Q. Sorry.

A. It was the meeting with the PIRC. I'll stand to be corrected, this is a few years ago, but I'm pretty sure it was with the meeting with Lindsey Miller and -- is that right? Would that be right.

Q. Lindsey Miller is from Crown Office.

A. Oh.

Q. And we've heard that there was a meeting with Kate Frame, who was then the Commissioner, and with her investigators.

A. Yes.

Q. But there were other meetings with Crown Office also.

We've heard that concerns were raised about Dr Karch.

A. Yes.

Q. But if you don't remember that is not --

A. I don't remember which of those meetings, but I certainly remember raising them.

Q. All right. Thank you. Let's have a look at paragraph 16, please, if we can bring that up:

"I am asked how this was becoming clear. It was becoming clear from my work alongside Aamer Anwar with the family and then the discussion that were coming out of the meetings. There was a lot of defensiveness from the PIRC and the Crown Office in response to legitimate concerns being raised. Without meaning to be disrespectful, it felt quite shambolic and rather inexperienced, in the sense of not taking on board some of the concerns that were being raised. It didn't feel that it was an investigation that was being led to uncover the truth. It felt more like an investigation that was trying to deny the concerns that the families and their lawyers were raising about the circumstances in which Sheku died. That was also not assisted by the role of the Police Federation and the misinformation that was appearing in the media. I thought it was absolutely reprehensible that the pathologist who had been instructed, Karch, then did an interview with a

newspaper about alleged drug use. I believe this to be such unprofessional behaviour from somebody who is supposed to be an independent expert and a clear attempt to create a narrative about the death that excluded restraint. There appeared to be press briefings of selected material designed to demonise Sheku out into the public domain relating to information about alleged drug use. This is a familiar pattern we have seen over decades wherein the State orchestrates narratives centering on the supposed criminality and violence of the deceased. In this case, the expert was implying drugs were the primary issue in Sheku's death. It was also interesting to note that the Police Federation drew attention to deaths in England and Wales where an inquest or coroner made reference to ED, excited delirium."

A. Yes.

Q. "... and ABD, acute behavioural disorder, but not to the clear concerns many of these inquests revealed in relation to the dangers of restraint. The combination of all the other things that were happening just didn't really inspire trust and confidence."

That's a big paragraph.

A. It is.

Q. I would like to go through some of these elements with

you. You have talked about how the context, the situation did not inspire trust and confidence.

If we could look through this. You talk about -- if we can go back to the top please, you said:

"It felt shambolic and rather inexperienced."

Is that in connection with meeting with PIRC or Crown Office or both?

A. I mean I think initially it was with the PIRC and, you know, not forgetting, of course, that we also, you know, had the context of the way in which Sheku's family and friends had been treated from the outset as potential suspects. And I think what it felt like to me was that the legitimate concerns that were being raised by the family and their lawyers and myself were just being dismissed. They weren't being -- they weren't being heard and I think, increasingly, you know, the family -- the family started to, you know, very quickly lose trust in, you know, the investigation process.

Q. When you mention the word "suspects", can you explain what you mean by that?

A. I think -- I mean I believe -- and obviously, I'm at a disadvantage in the sense I have not been able to hear all the evidence from the Inquiry, but the fact that, you know, the family had heard about the death of their loved one in the most appalling circumstances, but then

the way in which, Collette, his partner at the time was treated. The way -- the difficulty the family had in establishing what had happened, the way in which some of his friends were treated. You know, this is a grieving family and the worst thing has happened to them and so to have that experience very early on is bad enough, but then to then not have their concerns listened to and almost begin that kind of almost like fight to try and find out what happened and to get the investigation to do the job that it should do, not just in the family's interests but in the public interest. That's why we have an independent investigation process for these deaths.

And so obviously we knew from the outset that Sheku had died whilst being restrained by police officers and so that was particularly important that that was most, you know, most rigorously looked into because, you know, I knew from previous deaths in very similar circumstances that all too often the significance of the restraint and the contribution of the restraint to the death can be, you know, too often overlooked and, you know, you have brought up the issue of excited delirium or acute behavioural disturbance and, you know, the focus on ED as some kind of, you know, diagnosis that's used to try and in a way deflect attention away from

restraint that was concerning. And what I was trying to do is say to the PIRC, you know, don't fall into that trap, make sure you rigorously investigating and use the experts who have got experience in all of this to do so.

Q. Thank you. And then your response at 16 goes on to say:

"This was also not assisted by the role of the Police Federation and the misinformation that was appearing in the media."

A. Hm-hmm.

Q. I wonder if you could expand on that?

A. Well, I think what I saw was an attempt to present the police as peripheral to what happened and, you know, the information that came out into the newspaper from Steven Karch I think was quite a good example of what I was concerned about and what I had seen over a number of previous cases where information is put into the public domain about the alleged drug use of the person who has died in a way to deflect and deny the contribution that restraint may have played, but also that attempt to try and demonise and blame the individual for their own death. And for that information to be put out into a newspaper by somebody who is professional, that's reprehensible conduct.

And I have seen it in previous cases and in any way I think it's what I say about alarm bells ringing to me

about the way in which this investigation was being conducted. And, you know, that was -- that's a very good example of that and I think -- I think I also, you know, the other -- the other issue that was kind of happening alongside that was the concentration was on the purported violence of Sheku on alleged drug use, rather than on how he died and the fact that he had died following an encounter with the police and following restraint by a number of police officers.

Q. And you've talked this morning about thematic work?

A. Yes.

Q. And the work of Inquest over 40 years and your own involvement for over 30 years. Were these parallels that you were beginning -- that you felt were beginning to emerge from your understanding of the investigation into Mr Bayoh's death?

A. Yes, and it was also what I was trying to ensure didn't happen, hence my involvement. You know, I was very privileged to meet the family at a very early stage and their lawyer and one of the things I was very keen to try and avoid was making mistakes that I had seen being made in the England and Wales jurisdiction, You know, and the fact that we're sitting here nine years on from Sheku's death in a public inquiry kind of really, I suppose, reiterates that point, which is precisely what

we were trying to avoid.

Q. And can we just go back up to -- go to the bottom of that where you talk here about:

"The State orchestrates narratives centering on the supposed criminality and violence of the deceased."

Is that really a summary of what you have just been describing to us?

A. Yes, and I think particularly where the person who died is from a black community, that's where we very much see those kind of racialised constructions that, you know, equate black men with criminality and dangerousness. And, you know, I was very disappointed, but particularly upset for the family, because it's really difficult to put across what it's like for a family to go through these processes, but then to see the attempts to kind of demonise and dehumanise the person that they have loved who has died, you know, I know from my conversations how painful that has been and it should not have happened.

Q. Thank you. We've heard evidence from a Les Brown, who's a member of Crown Office staff, at that time he was the head of criminal allegations against the police and he worked in that department, and his recollection was that you also spoke about the disproportionate police use of force against black men when you were at a meeting with Crown Office. Would that -- would you recollect that as

correct?

A. Yes, absolutely, yes.

Q. Yes. And he also recalled you raising the idea of consideration of racial tropes and stereotypes of police officers dealing with black men?

A. Yes.

Q. Would you have discussed that as well?

A. I would absolutely have discussed that, yes.

Q. All right. Thank you. And he recalled you talking about excited delirium and that being a racial issue of itself?

A. Yes.

Q. His recollection about those topics is correct?

A. It is.

Q. Thank you. Now, I simply want to ask you, you have obviously had involvement with the family of Mr Bayoh, and I wonder, reflecting now as you sit here, what impact, if any, this prior involvement with the family -- you've said you respect the family -- your prior involvement with them, what impact has that had on your ability to give evidence to this Inquiry and to assist the Chair in an independent or objective way about your experiences with Inquest and the data that is available to Inquest about -- over 40 years about families and their experiences?

A. I mean I think in my role as director I navigate lots of different arenas. A day-to-day basis I could be giving evidence to a parliamentary inquiry or committee, I could be meeting with a chief coroner or a minister and I can be in the afternoon sitting down with a family and I am a professional. I have -- it has been my lifetime career and I think I have that ability to be independent.

You know, I say -- I say what I think and I'm uncompromising in that, but my evidence and all the work I have done is evidence based. It is based on those years of working alongside bereaved families, but also through the investigations, through inquests, through government commissioned reviews, you know. And the very fact -- I mean I think there's no better illustration than probably my independence and professionalism than to be appointed as a special advisor by the former Home Secretary and Prime Minister Theresa May and I don't think that would have happened if there had been any question about my ability to be independent and give advice and evidence based on my long-term career.

Q. Thank you. If there was anything -- during the course of your evidence today, if at any stage you feel your prior involvement with the family may be impacting on some of your evidence, would you please just let us know

and draw that to the Chair's attention.

A. Of course.

Q. Thank you.

Now, I would like to move on. Can we look at paragraph 82, please. I think it's of the second statement. Yes, 607, and it says here:

"This is why it's important to talk about racism because it's about how these perceptions manifest in police culture and practice, which means that they see a black man who may well be exhibiting bizarre behaviour or may well be in a mental health crisis, that can be because of mental ill health, it can be as a result of drugs, but they are in crisis. Rather than recognising that that person needs care and protection because they're particularly vulnerable, the default is they will go in and use force against that individual to contain, to gain compliance and control, rather than recognising this as a medical emergency."

Now, this is an example of part of your statement, but do you consider Inquest in any way to be antipolice or against the police in general?

A. No, I mean, I'm clearly concerned about when police abuse their powers or where they use excessive and unreasonable force and I do think as well that there are questions, broader questions than this inquiry is

looking at, about the use of police in situations that may well require a different response and I use mental health is a very good example. I think the police should not be first responders to people in mental health crisis and, indeed, I have talked to a lot of police officers who completely agree with me.

But, no, I mean as I said from the outset, the work that we do is evidence based and so the recommendations that we have developed over the years is informed by that evidence, that work with families, that overview of seeing a pattern of deaths that cause concern.

Q. And as a charity, as an organisation, do Inquest wish to work with the police to improve matters?

A. I think our objective as a charity is to try and prevent deaths happening and so one of the reasons why we are on -- for example, we sit, I sit as Inquest on the Ministerial Board On Deaths in Custody, which is a group that brings together representatives from a whole range of different public bodies, including the police, is to share our knowledge and expertise in the hope that we will ensure the learning and the change to stop deaths happening and that's -- our primary objective is about learning, accountability and prevention.

Q. Thank you. Can I ask you to look at another document now please, WIT87. And you'll see that this is headed:

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

Now, I think George Floyd died in the May of that year?

A. Yes.

Q. And this is from the December of that year?

A. Yes.

Q. And this is the month following the official commencement of this Inquiry. So for your information, we were in the process of beginning the process of gathering in documents, but no evidence had been started at that stage.

Can we look, please, at paragraph 19 of this document and here -- there's a specific mention to Mr Bayoh.

A. Yes.

Q. "He died age 31 following restraint by five police officers in May 2015 in Kirkcaldy, Scotland. He was stopped by police after they received a call about a man

behaving unusually. Within 46 seconds of the arrival of the first two officers, he was held face down on the ground. During the restraint officers used CS and Pava spray, batons, leg and ankle restraints and handcuffs and he was held face down. It is also alleged that two of the police officers involved had placed their full body weight on his upper body. He was unconscious within minutes of the restraint being applied and was pronounced dead at the hospital an hour and a half lawyer. A postmortem revealed he sustained facial injuries, bruises to his body and a fracture to his rib. Four and a half years after his death and as a result of concerns about the investigation of his death the Scottish Government announced a public inquiry into his death which is ongoing."

So there's specific mention to Mr Bayoh there?

A. Yes.

Q. Now, it may be suggested that there are errors contained within this paragraph. And it -- the question of fact, the Chair has heard all the evidence and it will be a matter for the Chair, but it may be suggested that it was not correct to say that during the restraint officers used CS and Pava spray, as one example, that it was used prior to the restraint.

There may be a suggestion that to use the phrase

that the police received a call about a man behaving "unusually" is not a fair reflection of the evidence that this Inquiry has heard that members of the public made a number of 999 calls, they were alarmed that Mr Bayoh was holding a knife at that time.

And I'm interested in this paragraph and the question of what is the source of information for Inquest? So in December 2020, when this document is prepared and you're providing information about the death of Mr Bayoh and some of the information contained in here is correct and isn't in any dispute, we know he did die age 31, and I'm interested in the source of information that you have at a time when no evidence has been led --

A. Yes.

Q. -- in front of any criminal proceedings, inquests, inquiries, civil proceedings, no witness has been sworn in.

A. Yes.

Q. Can you help us understand the background to how you prepare these things?

A. So the information that we would put and hear would be based on information that we will have gathered from media reporting, from knowledge that we may have of the case, but obviously with -- with Sheku Bayoh, there was

a lot of information out there, and, of course, at that point, none of it had been tested and, as you say, the Inquiry hadn't started. So what we try to do there is give an overview, but clearly, without the benefit of the evidence being tested and the Inquiry being set up, it's based primarily on media accounts and knowledge that we had about the case.

Q. And where would that knowledge of the case come from?

A. I mean from recollection when this document was being drawn up in 2020 that would largely be -- I mean I would have had some of the meetings with the PIRC, but, obviously, I'm also quite careful about issues around confidentiality and, you know, it's quite important before, you know, an inquest or before an inquiry that, you know, you don't mind direct comment on, you know, what has actually caused a death and so I think the way in which we've written this is to try and give an overview, but clearly not come to any concrete conclusion as to how he died and what actually happened.

Q. All right. And is there a mechanism in Inquest where you can verify information that you have gathered from accounts and media reporting and knowledge of the case?

A. I mean largely it would be through also talking to the lawyer involved in an individual case as well. So it would be a combination of things, because obviously

media coverage cannot be always relied upon.

Q. All right. Thank you. And if information was subsequently found to be incorrect, for example, if Inquest became aware at some stage that things that had been said previously were wrong, would there be an attempt to correct that information if an opportunity arose?

A. Yes, and also -- I mean I think it's also worth saying that the United Nations, when you put in submissions to the UN, they also where it's -- where you talk about individual cases, they also make representations to the UK Government. So you know, they have in any way their own way of kind of verifying and checked up on information, because they ask questions, so that would be the same for Scottish Government in Sheku's case, but also the other cases that we've put in there as well.

Q. Right. And there's just one last thing I would like to deal with and that relates to SBPI 00513, and we will come back to this later today, but this is a document prepared by Inquest called ' I can't breathe. Race, death and British policing" and this is the full report.

A. Yes.

Q. And there's an introduction on page 12 of the PDF, which we can see. I believe this was written by you; is that correct?

A. No, it's written by somebody we employed to do the research.
Q. Oh, I see.
A. Raekha Prasad.
Q. And that's a member of staff in the Inquest?
A. Yes, she was employed to do this research and bring this document together.
Q. All right. Thank you. And you see there it says "Background" and it mentions in 2020:

"... the image ... 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 daylight on British streets years before George Floyd's reverberated around the world.

"Among them are ... "

And a list of names mentioned and one of them is:

"Sheku Bayoh who died after being restrained by Police Scotland officers in Kirkcaldy in 2015."

A. Yes.
Q. And again, can I ask you what was the source of information that you had or your member of staff had, if you're aware, that that those words were expressed by Mr Bayoh?

A. From the family and their Crowd Justice document, I can't remember what you call it, the website. I mean talking to family, but also, again, couple of interviews that were in the newspaper quite soon after Sheku had died.

Q. And if subsequently it became clear that there was no evidence that those words were expressed by Mr Bayoh, is that something, if you had an opportunity, that you would endeavour to correct?

A. Yes, I mean I think I would also say that, you know, the title of the report and "I can't breathe" specifically really was an opportunity to try and make or raise greater awareness about the pattern of deaths that I talked previously about where people have been, particularly black people, have been restrained to the point of death and that quite often the struggle against is the restraint is because they can't breathe.

And I think "I can't breathe" obviously has taken on, I suppose, a more powerful and symbolic meaning more generally following those, you know, shocking images of George Floyd being killed, but what we wanted to try and demonstrate with the report is that there were a disturbing pattern of restraint-related deaths where people had died because they could not breathe.

Q. And if you had known that -- or become aware if it was

decided that Mr Bayoh did not utter those words, would you simply have removed his reference from this paragraph but remained -- continued to include George Floyd, Kevin Clarke and Seni Lewis?

A. Yes.

Q. And George Floyd, Kevin Clarke and Seni Lewis, were you satisfied that those were words that they spoke?

A. I mean there were other names we could have put in there and I take full responsibility for putting in Sheku Bayoh's name I would add, because I was keen to demonstrate that this was a UK problem, but I hear your point and, yes.

Q. But there were other names that could have substituted for Mr Bayoh?

A. Yes.

Q. Now, I'm conscious of the time and I want to move on now if I may.

THE ARBITRATOR: We'll take a 20-minute break.

(11.32)

(A short break)

(11.56 am)

LORD BRACADALE: Ms Grahame.

MS GRAHAME: Thank you.

I would like to move on to deal with another topic, but to return to a document we have already looked at,

WIT 87, please, and this was the Inquest submission to the UN in December 2020 and I would like to look at paragraph 10, please:

"Through an analysis of our casework, Inquest has identified that the racial stereotype of big black and dangerous, violent and volatile, when woven into the culture and practice of the police, has become a recurring feature [in] deaths following use of force and restraint by police in the UK."

So I think that should be "recurring feature in deaths following..."

A. Yes.

Q. "In cases where people have had mental health needs, additional negative imagery and stereotyping, mad, bad and dangerous, has informed their treatment. We are particularly concerned about the double discrimination experienced by black people with mental health issues."

And we've heard from a Professor Meer in the Inquiry who talked about intersectionality where people with perhaps more than one protected characteristic can find that the discrimination is enhanced because of that intersectionality?

A. Absolutely.

Q. Yes. Can we look at that two examples that you give in this submission, paragraph 12, first of all, and this

relates to mental ill health and restraint and the person mentioned is Sean Rigg, who was 40 years old.

And I'll read this out for a moment, but did Inquest have direct experience in relation to the death of Mr Rigg?

A. Yes, we worked with the family from the outset and indeed Marcia Rigg, Sean's sister is on our family reference group and is also one of our members of board of trustees.

Q. And we hope to hear from Marcia Rigg later in the hearing.

I will read this out and then I will ask you some further questions:

"Sean Rigg, 40, died of a cardiac arrest following an eight minute prone restraint by Metropolitan Police officers in 2008 when he was experiencing a mental health crisis. In 2012, the Inquest jury found that his death was contributed to by a litany of failures, including that the police failed to identify that Sean was a vulnerable person at the point of arrest and take him to an accident and emergency department rather than a police station. An officer involved in Sean's arrest was captured at the custody desk saying 'I hope he hasn't got anything. I've got his blood on me and he is faking it.' When Sean was eventually carried out of the

van, he was shown to be slumped and unresponsive. In this case, as in others, a racialised fixation on dangerousness by law enforcement personnel meant they failed to consider his welfare and safety. A jury at his Inquest concluded whilst in custody, the police failed to uphold Sean's basic rights and omitted to deliver the appropriate care and that restraint in the prone position was unnecessary and unsuitable."

I would like to go through some elements of this paragraph with you, if I may. You've talked about how Mr Rigg was experiencing a mental health crisis and you say:

"The police failed to identify that Sean was a vulnerable person at point of arrest and take him to an A&E department rather than a police station."

A. Hm-hmm.

Q. I'm interested in that as a theme that there's a failure to recognise a medical emergency. Could you tell us more about that?

A. I mean I think in this context Sean was known to be vulnerable and was certainly in a mental health crisis at the time and what one of the things that we've noticed in our monitoring work and obviously our casework is that rather than officers stepping back and containing and de-escalating a situation, we see that

default to the immediate use of force and of course on somebody who is in a mental health crisis -- now that can be because of mental ill health, it can also be because somebody is intoxicated be that with drugs or alcohol and so can be extremely confused and agitated.

And the use of restraint and, in particular, the restraint until somebody is subdued and stops struggling is ultimately the point at which in many cases somebody is going -- is dying or is indeed dead. And I think with Sean's case, one of the concerns that we had, amongst many, was the fact that the expensive prone restraint that he was subjected to culminating in his ultimate death.

Q. In the experience of Inquest -- we have heard evidence that Sean Rigg was a black man.

A. Yes.

Q. And in the experience of Inquest, is there a disproportionality that's been identified about how a white man in mental health crisis is treated compared to a black man in mental health crisis?

A. I think what our monitoring has shown is that with black men in particular, it's the point I made earlier about equating black men with dangerousness, with violence, with super human strength, some of the language that you hear. But then when you also consider some of the

tropes around mental health and that kind of idea of mad, bad and dangerousness, if you have got the intersection of both of those, then that can be fatal and we mention other examples.

And I mean I think it's important to say that, you know, there have been deaths of white people and I'm thinking the death of, for example, James Herbert, who was restrained by police officers culminated in a significant report by the IPCC called "Six Mischances", which was about treating people with mental health as a medical emergency.

And obviously, Sean's case, like that of Olaseni Lewis, they were the two quite significant cases that led to the setting up of the Angiolini Review.

Q. Right. And from the experience of Inquest is there a difference noted -- you've mentioned containment and de-escalation, have Inquest noted a difference between the speed at which officers resort to use of force in relation to a black man in mental health crisis, compared to a white man?

A. Yes, in particular in our various reports what we have identified is the immediacy of the default to use of force and that's -- in terms of Sheku, it's one of the things that concerned me when I first learned of Sheku's death was what I was told about the very short time from

which the police arrived and to the point that he was restrained, and that is definitely a pattern we have seen and continue to see in our casework.

Q. And is that a pattern that you see in relation to black men, as opposed to white men?

A. Yes.

Q. And then you mentioned Olaseni Lewis or Seni Lewis, if we look at paragraph 13, again, was this an incident that Inquest had direct experience with?

A. Yes, we worked with the family and their lawyer.

Q. Thank you:

"Olaseni Lewis, 23, died in 2010 in a mental health unit where he was a voluntary patient. Multiple failures at multiple levels meant hospital staff called on the assistance of the police when Seni became unwell. His death followed two successive periods of prolonged restraint by 11 Metropolitan Police officers. At the inquest into his death in 2017, the jury found that the use of restraint, which included the use of mechanical restraints, was found to have been excessive, unreasonable, unnecessary, disproportionate and contributed to his death. The jury concluded that there was a failure on the part of the hospital staff and police officers alike to provide basic life support when he collapsed under restraint.

"Racist and dehumanising stereotypes were employed by police officers to defend their actions during the inquest: 'We didn't immediately call a doctor when he became unresponsive, because we weren't 100 per cent sure if he was definitely unconscious or not breathing. We left the room in any case he was feigning, passing out as a ploy to escape'."

So again, a number of issues emerge from this paragraph. You've identified that the police became involved and carried out a prolonged restraint, which you have mentioned. And this was described as excessive by the jury -- the inquest jury.

The failure on the part of hospital staff and police alike to provide basic life support when he collapsed under restraint, again, from the experiences that the Inquest have, is this a theme that you see a pattern that you see?

A. Yes, I mean I think in particular this suggestion that somebody is faking unconsciousness, faking it, despite the fact that clearly they're in a critical point of death or indeed dying, and that's a pattern that we've monitored, sadly, for a very long time and continue to monitor. And that I have to say doesn't just, you know, it's not just in the context of police-related deaths, it's also in the context of prison and mental health.

And I mean you have already said that the shocking aspect of this is that Seni was actually in a mental health setting, you know, somewhere where one would expect -- his family certainly expected that he would be safe and he was -- he was subjected to that prolonged and dangerous restraint.

Q. And have Inquest noted a difference in the way white men are treated compared to black men in this type of situation?

A. I think particularly about the stereotypes that I have referred to, the racist and dehumanising stereotypes that we've seen. And that goes, you know, that also comes out at Inquest where there's language used about people being, you know, impervious to pain and animalistic kind of noises being made. I mean I have alluded to some of them in my statement, but, you know, I think the issue around just that culture of kind of disbelief when somebody is going into, you know, crisis who's, you know, who's dying, is that feigning it, you know, faking it is something that we hear too often.

Q. Right. And in relation to racist and dehumanising stereotypes, this is mentioned in the submission and you have also mentioned this aspect in your statement, I think in 607 at 71. We can put that on the screen.

I think at paragraph 71 you talk about the themes

emerging and you mention Olaseni Lewis, Sean Rigg and you also mention a case of Mark Duggan?

A. Yes.

Q. You say at 71:

"I am asked whether I can speak from my experience with families bereaved by State-related deaths, about any common themes relating to interactions between black men and the police."

And you talk about the 40-year history Inquest has:

"When we've looked at these issues, we situate police killings or deaths following the use of restraint on black people within that broader and longer history of police contact and harassment. These by their very nature have been and continue to be the most controversial and their consequent impact on police and community relations has been profound. These deaths connect with the black community's experience of structural racism and the discriminatory over-policing and criminalisation. They have been the catalyst for considerable public anger and community-based disturbances in response to what is perceived as pervasive State violence with impunity.

"I have mentioned around the disproportionate stop and search, use force and how that then makes death more likely."

I'm interested in asking you, first of all, about the impact on the public and on the community in a wider context of these incidents?

A. I mean I think there is no doubt that, you know, a number of -- a number of death and, as I say, obviously we're talking over decades, have taken place in black communities that have had experiences of over-policing and have also had experience of high-profile deaths in custody.

And, you know, not only do you have to understand, you know, the community trauma alongside, you know, the family trauma of, you know, a death following contact with police officers, but then the way in which you see how these deaths take, you know, many, many years very often before there's any conclusion. I have talked already about the kind of misinformation, that kind of culture of delay and denial and defensiveness, but also many, you know, many of these deaths raise, you know, really disturbing evidence about how somebody has been treatment -- how somebody has been treated and about, you know, extreme violence used against them.

But then to see the fact that nobody is ever held to account, either at an individual or at a senior management level, for what's happened, then that creates, you know, real community anger and mistrust of

the very agencies that you look to to ensure that people are held accountable and that there is change. And you know, sadly and I think most frustratingly from my perspective is that we've just seen death after death raising the same issues of concern and yet those deaths keep happening.

Q. And I was going to come on and ask you about the impact on the families and the family. You've described it as family trauma in your evidence. And is that really a description of the experience of families in this situation?

A. I mean I don't think there's any other way to describe it. I mean it is a traumatic bereavement in that it's unexpected, it involves the State, and then you effectively have the State controlling the -- everything that follows, the -- you know, the investigation, the body -- the body in effect belongs to the State. And then families, you know, in a way families grieving has to be put on hold while they try and navigate the various legal processes that follow.

And you know, what families tell us time and time again is, firstly, of course they want the truth about what's happened and they want -- if there's wrongdoing or criminality, they want people held to account, but most of all they want it to stop happening to somebody

else. And one of the things that I don't think is understood is the added trauma for families that we work with who've looked to these processes for change to then hear about another death in similar circumstances.

So the -- you know, for a bereaved family there is not just the trauma of the individual death, but the very processes that they have to engage with can be re-traumatising, before they have a kind of conclusion that, you know, hopefully means that they can then begin to start grieving. But, you know, there's also a really shocking lack of kind of bereavement counselling support available to families. I think there's a lack of understanding from some bereavement organisations about the additional trauma where you have a death that involves protracted investigations and, you know, I think that families are very often just, you know, quite isolated, left to effectively get on with it.

And as I said, you know, this morning in relation to Sheku Bayoh's family, you know, I think people forget that this places a huge emotional and physical toll on families, you know, whose lives are effectively put on hold whilst they -- the various legal processes do their job.

Q. Can we move on, please, to the same statement paragraph 78 and this follows up on what you are saying a moment

ago about faking it:

"Another theme that's come out of the some of our work on deaths of black people has been when officers are asked 'Why did you do continue restraining somebody when they effectively stopped breathing or they're dead?' the amount of times you hear reference by a police officer to someone feigning unconsciousness or faking it and the culture of disbelief and disregard to health and being of the person in a state of collapse death or near death. Further evidence of the criminalisation and dehumanisation of the deceased to justify police violence and blame the victim for the violence and neglect they experience."

Can I ask you about -- we've talked about death.

A. Yes.

Q. Can I ask you about any themes that have emerged in Inquest's work that identify failures or delay in providing first aid to a person who's in that situation?

A. I would suggest that that probably characterises quite a lot of the deaths that we are involved with and then failure to recognise that the situation is effectively a medical emergency. I mean I think that's something that's come out of training, maybe, you know, much more recently, well, in fact around the time of the Angiolini Review.

But I think one of the concerns that I have around restraint-related deaths is the -- you know, I think it's well -- people are well aware of the potential dangers that restraint can bring, particularly prone restraint, and one of the things that I have seen in a lot of these cases is where police officers appear to have kind of lost sight of the person as a human being and that lack of recognition that the struggle against restraint, which they perceive as violence and, you know, quite often results in even more force, that struggling is often borne out of fear, out of distress, but significantly the struggle is the struggle to actually breathe.

And of course, you know, in those situations where somebody is having their breathing compromised, of course that's a medical emergency. But what we've also seen and I think there's a reference to the death of Kevin Clarke is, you know, it's -- there are situations where, you know, medical staff have failed to intervene at a more -- in a more timely way and have effectively given control to police officers, rather than recognising the life-threatening situation that somebody is in.

Q. And you've seen that pattern emerging in the evidence available to Inquest you have just.

A. Yes.
Q. We've touched on the issue of feigning, medical assistance, first aid, and matters of that sort, as a body that has experience of these matters, has Inquest reflected and concluded any views as to how that situation could be improved in relation to perhaps lack of first aid or a delay in providing first aid, a delay in recognising a medical emergency?
A. I mean I think at inquests and in coroner's reports prevention of future death reports or what previously used to be known as Rule 43 reports, some of which I have provided to the Inquiry, there have been recommendations or certainly suggestions to police and health about some of the things that could be changed and, indeed, a lot of the evidence that we heard as part of the Angiolini Review -- I mean one of the things that I think was so important about the Angiolini Review was the fact that, you know, it looked into these issues in depth and we had meetings with, you know, with health with police, with families, as you've already heard, and there were a whole series of recommendations that were very much designed to try and, you know, stop this pattern continuing and across all deaths, not just deaths, obviously, of black people.
But as I think I said earlier on, you know, I think

if you're talking about people in mental health crisis or otherwise in crisis, it's really important that there's a recognition that these are, you know, these are people who are in potential serious risk, not least if restraint is applied, and that knowledge is well-known.

Q. Thank you. Can I move on to return to a topic we've touched upon earlier in your evidence, media engagement and misuse of information.

If we look at SBPI 366, which we have on the screen, and paragraphs 60 to 65, and I think here you talk about common concerns about misinformation. There we are:

"The most common concerns that families report are the use of misinformation and spin, which has been a long-standing feature of many conscientious deaths in custody. Families have regularly reported that before the involvement of the independent investigation has started, the police force has very quickly sought to defend its position by releasing their narrative about events to the public before the basic facts have been established. There are numerous examples of this, some of which Inquest included in a submission to the Leveson Inquiry, in where we described a recurring issue of concern to bereaved families and the police who work with them, misinformation following deaths involving the

use of lethal force by the police.

"They highlighted that misinformation about such contentious deaths not only damages bereaved people, but it also determines public confidence in authorities. Misinformation following contentious deaths makes it hard to allay any suspicions of wrongdoing and failures in the minds of bereaved families and the public at large. As well as obscuring the picture of what happened, misinformation fuels fears that the State is attempting to deliberately prevent information about its own culpability in deaths become publicly known.

"Many families have described how they felt that instead of the death of their loved one being investigated, it was their private life and that of their relative that was subjected to the most scrutiny. Families regularly find, as well as promoting their own version of events, police sources have briefed the media with prejudicial, irrelevant and in some cases inaccurate information about the deceased intended to besmirch their reputation and blame them for their deaths to deflect attention away from the acts and omissions of officers or public bodies, instead of focusing on problem or dysfunctional families and the deceased's criminal or antisocial behaviour."

If I can stop there for a moment, you talk about the

deceased, the family, and the public. Could I ask you about what themes you have seen emerging regarding the deceased, first of all?

A. So I mean I think effectively trying to blame the deceased for their own death by reference to drugs, purported violence, I mean, you know, gang involvement, a whole kind of serious of -- I mean depending whether you're talking about -- if we're talking about black people in particular, black men in particular, that kind of very, very powerful and racist trope that we see about, you know, gang engagement, gang involvement, drugs, and by focusing on the alleged violence of the person who died.

So in a sense before the investigation is really, you know, carried out or there has been any conclusions made, reference to information that is an attempt to other or to, you know, to focus on the deceased's alleged criminal or criminal behaviour, rather than on the fact that somebody has died in a really disturbing way that warrants proper scrutiny and investigation.

Q. You mention tropes and you've mentioned a number of themes that you have seen emerging.

A. Yes.

Q. Gang involvement, drugs, and the violence or criminal behaviour of the deceased?

A. And mental -- and mental health is another one.
Q. And you have seen common themes were those issues are given as part of a narrative.
A. Yes.
Q. And then for the family, can you help the Chair understand what themes are on or patterns you have seen emerging in relation to how they're portrayed or how they're dealt with?
A. I mean I think I come back to this in my earlier -- sorry, my later statement but, you know, families who ask -- who are asking legitimate questions after a death being seen, you know, as troublesome or difficult or -- and then, you know, communities, you know, I have said -- I think I have said before that, you know, there are a pattern of deaths in, you know, particular communities, particularly in London, where I think, you know, communities themselves who perhaps will protest and will ask questions of police as to what's happened are, you know, effectively also criminalised by the very fact that they're asking and trying to actually understand what has happened.

And those are in my view are very legitimate questions, and they are questions in the public interest. The state does do and the police in particular do attempt to deny and deflect when those

questions are asked. And for families, I think particularly for bereaved families, I think it's extremely difficult when you are grieving to then see your loved an -- attempt to demonise your loved one for something that has happened follow their encounter with police officers.

Q. And you mentioned in paragraph 62 about families feeling they're subjects to the most scrutiny. Can you explain that?

A. I think that what often happens following an investigation is that families feel as if the investigation is as much focused on them and their loved one rather than on what happened to their loved one, you know, in or following police custody. And, you know, the kind of resource that's put into effectively scrutinising the family and the person who died, I think sometimes feels disproportionate to the investigation that's being carried out into those in whose care or custody individual died.

And I suppose it goes back to an earlier point which is, you know, about kind of that when families find themselves involved in these processes, too often they experience that attempt to somehow dismiss their legitimate concerns or to try and blame the person who died for their own -- for their own death and I would

suggest that with Sheku some of that media representation about his, you know, alleged assault on a female police officer and his purported violence and the information about drugs that came in just to me characterised what we have seen do often when it comes to these deaths.

And I think what it does as well is it creates in the public mind -- it creates that idea of an undeserving victim. And when that information enters out into the public arena, it's very difficult to challenge it not, least when, as we know, these processes are protracted ones.

Q. Touching on -- you've talked about the State in paragraph 62. You talk about fears:

"Misinformation fuels fears that the State is attempting to deliberately prevent information about its own culpability in deaths becoming publicly known."

I'm interested in that aspect. Is that a pattern that you've seen emerging from a number of these deaths?

A. Yes, absolutely, because if the -- if there's an attempt to smear, you know, the character of the deceased and their family and there's a lack of openness and transparency about what's happened and if the investigation is not doing the job that, you know, the public at large and that legally it should be doing,

then I think that what you then see is an attempt to explain away what's happened, rather than understand how and why it has happened and, importantly, how to stop it happening again.

Q. Can we move on to the next paragraph, 64. You say:

"Families reported having to defend not only their loved ones but themselves against racialised stereotypes from the outset and how they faced negative media reporting and inaccurate police statements that started in the immediate hours after a death occurred."

Can you help us understand about what you say there about they're not only defending their loved one, but themselves against racialised stereotypes? Have you noticed a theme in the circumstances that Inquest have dealt with that families are facing racialised stereotypes in their dealings with the institutions of the State that they're involved in?

A. Yes, and I mean I think -- I think I have reported on this in terms of through the family voice, because, you know, I think I need to be very clear here that my evidence, as I have tried to say, is based on working alongside families for a very long time and the team at Inquest do that day-to-day work and families that we meet with regularly that is exactly what they describe this as being like. And about the way in which they're

spoken to and particularly the way in which, you know, when they, in my view rightly, ask questions about what's happened, you know, they are -- they are seen as -- they are seen as difficult or hostile.

And also they also -- I think people forget that, you know, when something like this has happened, you know, it's the worst thing that can happen to a family and you're not only trying to deal with the post death kind of religious or cultural practices that then follow, you're also trying to navigate a very unknown complex and quite hostile process. You know, it's not -- it's not easy and then to find that you are almost having to kind of explain and justify your reason for asking questions about what happened to your loved one, and that's certainly something that families report and continue to report. This isn't something, sadly, that has, you know, has changed to the way it should have done.

Q. And then finally paragraph 65, you've talked about -- the introductory lines there, but you say:

"We have no doubt that police statements to the media in the immediate aftermath of a death in police custody and and during inquest processes play a key role in undermining family's confidence in the process, worse they can hamper the system's search for truth and, in

the most serious cases, lead to the promotion of an accepted public narrative of events that is simply untrue, but which families find it hard to dislodge. The focus of a police force typically becomes how to defend its actions, rather than to assess whether in fact its action fell short of expected standards and what learning and improvements can be made."

And does that touch on what you have been saying that there's less of a focus on improvements and understanding, but more on defensiveness?

A. I mean absolutely and I have already -- I have described that kind of culture of defensiveness, denial and delay. But, you know, I think my concern is that police tend to see the investigation and inquest or FAI process in this context as about reputation management and about defending policies and practices rather than -- and of course, you know, we have to also remind ourselves that, you know, Article 2 requires an effective investigation that is capable of identifying, you know, what happened, but, you know, importantly, it should also be there to ensure learning and accountability.

Because at the end of the day, the rule of law does apply to police officers and I think that the processes that we've seen and it's not Inquest, only Inquest who have been critical about some of these processes. This

is not an area that's without its research both academic, official, Home Office research and it's been the subject -- deaths in custody, police custody have been the subject of numerous reviews and parliamentary inquiries.

But you know, I still find the fact that what these processes in my view are too often focused on is explaining away rather than properly understanding what went wrong, how improvements and changes can be made to stop this happening to somebody else and of course it goes without saying that that's not just in the interests of, you know, bereaved families that we work with, it's in the interests of the public at large, but also it's of course in the interests of the police officers who have to go through these processes.

Q. And so you do say specifically there that in relation to this topic of media engagement or misinformation it plays a key role in undermining families' confidence?

A. Yes.

Q. And that is the trust and confidence they have in the investigation and the outcome.

A. Yes. Particularly where they see the police misrepresenting evidence and I believe in my -- in my last statement I give the example of the more recent death in London of Oladeji Omishore, a man who was

tasered on a bridge in London, where the Metropolitan Police put out a statement saying that he was armed with a screwdriver, which of course immediately conjures up that image in one's mind when in fact it was a cigarette -- one of those fire lighters. And the family had to then try and get them to retract that information, but by then it's in the public consciousness, it's out there.

Q. And I would like to turn on to page 28, please. This is one section in your statement where you talk about best practice and I would like to go through the four items that you've listed here:

"A. Consideration should be given to preventing a police force whose officers' actions are being considered in an independent investigation from commenting on the matters in issue to the media at all."

And if changes were implemented along those lines, what impact do you think that would have on families?

A. Well, I hope there would be a little bit more trust and confidence in the fact that, you know, there's an investigation being undertaken and that police forces are not prejudging the outcomes of that information -- sorry, prejudging the outcome of that investigation.

Q. Thank you. And then:

"B. There should be no contact between the local

force and bereaved family where an independent investigation it to take place and they should the main source of contact after a death. Where this is felt to be necessary, it should be agreed with the IOPC and family lawyer."

I think the equivalent of the IOPC in Scotland is PIRC.

A. Yes.

Q. And do you think having no contact between the local force and bereaved family would be of benefit to a family?

A. I think so, yes.

Q. And why do you say that?

A. Just because I think, again, it's about trust and confidence. There's an independent investigation taking place and let's -- that's what families need to look to in effect be doing, you know, that investigation without, you know, having any engagement between -- it's unnecessary to have any engagement with the force and the family and that doesn't -- that doesn't mean that, you know, you can't treat somebody humanely from the outset and offer condolences. But in effect the independent investigation is what the State has given the family as their means to find out what happened.

Q. And:

"C. Any press release to be issued by [the PIRC] should be agreed in advance with the family of the deceased."

A. Hm-hmm.

Q. And tell us what benefits you think that would bring?

A. Well, the first thing I would say was just to make sure that it's accurate. I mean we have had examples of press releases going outwith misspellings of names or ages and so basic information, but also to make sure that you know, it's -- it's a neutral press release containing information that isn't going to further distress the family by reference to information that may well be incorrect or be found to be incorrect.

Q. "D. Inappropriate media briefings by the police should be commented on in the independent investigation and should be considered as a misconduct issue."

A. Yes, yes.

Q. And that would be briefings -- when you say by the police, are you thinking there of individual officers or Police Scotland as a body or even the Scottish Police Federation?

A. All I would suggest. I mean I think -- obviously, it's dependent on individual cases, but it should apply to anybody who's given inappropriate media briefings.

Q. Thank you. And we can move on from that.

I would like to some on to SBPI 607 and I'll be looking at the paragraphs 25 and 26. In this regard you've mentioned the deceased being demonised?

A. Yes.

Q. Family life being -- and the family being scrutinised --

A. Yes.

Q. -- and the impact? I'm also interested in considering whether this extends to the legal advisors who may be assisting and supporting the family. If we look at paragraph 25, first of all, you'll see around fifth line -- five or six lines down, it begins:

"I am also aware of this through ..."

Do you see that?

A. Yes.

Q. "I am also aware of this through the Undercover Policing Inquiry as some of the families, their campaign groups and their lawyers were spied on after deaths in custody. If they don't just got for the families, then they'll also try and go for their lawyers. Reflecting on my involvement with Sheku, I worked very closely with the family and Aamer, particularly in the early stages. Aamer contacted me because he knew of our work on deaths in custody, particularly on restraint-related deaths of black people. He sought advice from me because of my expertise."

And then you go on to describe that.

A. Yes.

Q. And we've talked about that. And then at 26 you say:

"What I have seen happening to Aamer over the years is there has been an attempt by the police, investigators and some of the media to demonise him for the work that he's been doing. Bear in mind that for many years Aamer Anwar was working pro bono in the absence of public funding. He was trying to ensure that the truth about what happened came out in the family and public interest. As an Asian lawyer he has been subject to the institutional racism seen in regard to other black and brown lawyers who take on the state -- where you try and undermine them despite the fact that what they're doing trying to do is ensure the most robust scrutiny of what's happened. I think it shows just what the resistance is when deaths like this happen to ensuring that they are investigated without fear or favour and in the interests of Justice."

And I'm interested in any patterns or themes emerging that Inquest have identified where not just the family of the deceased, not just the deceased or the family, but their friends and other family members and perhaps even their lawyers are being demonised in that way?

A. I mean I think -- I mean, firstly, I would say in regard to Aamer Anwar, you know, obviously, I know, because I have had contact with him since the outset, how hard, you know, he has been working in the absence of public funding. I think there's a perception often about lawyers that, you know, that this kind of -- I mean if you talk about tropes this idea of the fat cat lawyer, when in fact so many of the lawyers I have worked with over decades have done a lot of this work for no money whatsoever and, particularly, in the absence of legal aid funding for these case, which is of course in real contrast to the fact that public funds pay for the State to be represented.

But that aside, what I saw with Aamer and I have seen with, you know, other lawyers is the fact that what they were doing is trying to represent the best interests of their families to try and ascertain the truth about what's happened and to try and make the investigation processes -- do the job that they are -- that they are supposed -- supposed to do. And of course, you know, for many that's seen as -- that can be seen as highly problematic, because effectively it's also scrutinising the quality of the investigation and the way in which those investigators are conducting their work.

And so I have seen, you know, I have seen the kind of hostility to lawyers being involved in my work for a long time, but I think when you are a black or Asian lawyer, then the reality of racism is you see it in all organisations and all structures and I think it's quite easy to try and then target individuals. And I was quite, if I'm being, you know, very honest, I was very shocked to find out, you know, the experience that Aamer was having and, you know, maybe it is because, you know, he is somebody who has, you know, been out there, he has a media presence, he's involved in highly significant cases, particularly around, you know, institutional racism. But, you know, I -- I think that it's absolutely kind of abhorrent that you have a situation where a lawyer who is doing the right thing for their families are then themselves, you know, targeted for that kind of, you know, behaviour and that kind of demonisation that we've already talked about in the context of the person who's died, but also their families.

Q. And do Inquest see and a difference in situations and the impact on the lawyers and the demonisation of the lawyers if the person who has died is black or if the person who has died is white?

A. I mean I think -- I think I would -- I would say, I may

well be corrected, I mean I am aware of other lawyers in England and Wales who have experienced similar treatment, but perhaps not more recently. I mean, obviously, I referenced the Undercover Policing Inquiry, but obviously that's -- that has a particular time period, but, you know, I think the experience that Aamer has, I would suggest is -- is unusual in my current experience.

Q. And as well as -- we've talked about demonisation, including of the lawyer, are there any other examples, not simply demonisation in the media, are there any other examples of behaviour towards or a narrative presented towards the lawyers representing families of someone who's died that you're aware of from your experience?

A. Well, I mean, I think what I said before in response to that question which is around, you know, lawyers are raising the legitimate concerns of their clients that they represent and that's a really important role, particularly where there are concerns with the way in which these investigations have been carried out and some people find that really difficult and find it that somehow it's, you know, it's judging them for what they're doing. But of course it's a really important role, because, you know, families put their faith in

their lawyer to, you know, play, you know, for them to play a meaningful part of the investigation and so to then be treated with, you know, contempt or to be dismissed for what they're trying to do in their client's interests is not acceptable, because families have the legal right to be represented throughout these process and the law is very clear on that.

Q. Thank you. I would like to move on to another topic, which if we look at SBPI 366, paragraph 70, you touch on this. This is issues regarding post-incident management, difficulties and delays in obtaining statements from officers. Paragraph 70 you said:

"As the Home Affairs Select Committee said in its report in 2013 on the IPCC:

"'The issue of interviewing officers in cases involving death and serious injury is indicative of a culture of treating officers differently from members of the public. Where officers are not interviewed promptly under caution, this can lead to weaker evidence and loss of confidence in the process of investigating serious matters, such as deaths in custody. The application of the threshold test for special requirements should be reviewed, so that officers are routinely interviewed under caution in the most serious cases, exactly as a member of the public would be'."

And this was the Home Affairs Select Committee. I think you have referenced it -- you have given the link at the bottom in the footnote 15 and you talk here about a culture of treating officers differently from members of the public.

Now, I am interested if Inquest has noted that issue emerging in cases that you have been involved in, a perception that the police are being treated more favourably than members of the public?

A. I mean I think that would be the overriding experience of the families that we work with and certainly chime. I mean the Home Affairs Select Committee I think have done a subsequent report to this where the same concerns about police officers particularly -- I mean it comes back to a point I made earlier on about the unwillingness to approach these deaths as if a potential crime has been committed, so that police officers are treated as witnesses and not potential suspects.

And I say that not -- not implying that all deaths, you know, are the result of police officer criminality, but it needs to be proven to be otherwise and particularly where you have a death following restraint, it's absolutely vital that police officers are interviewed in a timely -- in a timely way and what we see is that these -- this can, you know, drag on for an

extremely long time and in fact the taking of witness statements can often be frustrated by the Police Federation and the lawyers instructed.

And of course for families, you know, the idea that an ordinary citizen who has been involved in a situation resulting in death wouldn't be interviewed in a timely manner, I think that's -- that's what leads to some of the kind of lack of confidence in the processes for holding police officers to account, and as I said, it's been the subject to a number of inquiries.

Q. And from the perspective of Inquest, would it be appropriate to treat those very serious cases of involving deaths in custody or deaths after police contact, Article 2 investigations, in perhaps a different way to other types of case?

A. Yes, not least where a death is -- not least where, you know, police contact has resulted in death and restraint-related deaths are a very clear example of that.

Q. And do you think if that was done that that would to some extent rebalance this perception that officers are treated differently from the public and perhaps have an impact on public confidence?

A. Yes, and also it might assist the, you know, the timeliness of these processes, because, you know, as

we've discussed, they can be subject to serious delay and some of that delay can come because of the refusal of police officers to give statements under legal advice and I say that. But you know, it --

I mean I think the quote of the Home Affairs Select Committee probably does sum it up. But it's also -- I think it's what one should expect from the process for holding the police to account that, you know, where this has resulted in death, that, you know, we need to see those processes deliver the accountability that -- that, you know, we demand from the police. They -- as I said, the rule of law applies to them as equally as it does to a citizen.

Q. Can we turn to paragraph 47, please. And again you talk about something the Home Affairs Select Committee but this time in February 2022?

A. Yes, thank you, that's the latest inquiry that I was talking and I gave evidence to this committee as did a member of our Inquest lawyers group so it was -- it was a kind of more recent inquiry effectively saying the same thing, that --

Q. And you have given a quotation there. Is this from their report?

A. Yes.

Q. "There is a clear absence of urgency and a culture of

non-cooperation from some police forces involved in investigations."

A. Yes.

Q. Is that a perception that you have become aware of from families or and/or the public more generally?

A. Well, I think it's a perception from families but it's also the reality of families and I think it's important to note that's 2022, the previous inquiry was 2013, and most recently I was on a reference group to a review of the IOPC -- sorry, I think maybe it's in my statement somewhere, I can't remember -- and again where that whole -- that whole issue about police officers statements and accounts and the subsequent paragraph I think is also important which is around, you know, when police officers make their first accounts and, you know, the importance of separation of police officers when something like this has happened.

Q. Let's look at 75.

A. Hm-hmm.

Q. "Very significantly for families, the IOPC often miss the opportunity of ensuring that officers write their early first accounts without collusion or ensuring that any debriefing meetings are not merely an opportunity for officers to rehearse their evidence in front of each other (getting their story straight) before recording

their accounts. Police officers are usually the only witnesses to key events preceding the death and the integrity of their accounts is therefore critical to the integrity of the investigation overall. So long as officers remain together following a death, many families will have suspicions which undermine their faith and confidence in the investigation. Concerns about officers need for support and welfare considerations can be fully addressed by any relevant person to meet those needs so long as that person or persons were not witnesses to the relevant events."

And here do you explain that this situation can undermine again trust and confidence that the family have in the investigation?

A. Yes.

Q. Yes. And more generally what is the impact for families in this situation about this inability or delay in securing accurate information about what happened?

A. Well, I think -- I think the fact that the very people in whose care or custody their loved one was in and the failure to make available that information, you know, I mean you can only imagine what that's like on an emotional level but in the context of the fact that, you know, families have to look to the PIRC, in Scotland the IOPC and in England and Wales for them to conduct the

investigation to then know that timely evidence has not been taken does undermine their confidence in the ability of those investigations to get to the truth. And I think that what -- that's one of the really -- you know, one of the really frustrating aspects of our work is the fact that when something like this happens, it takes a very long time and families have to wait and the state and, you know, has control of all the information, you know, the families weren't there and so it's very hard to then know that the very people who were there are not -- are not giving -- are not giving statements or are not -- it's the kind of absence or the lack of candour I think is, you know, really difficult for families to understand.

Q. Thank you. If you could give me a moment. I'm conscious of the time, would that be ...?

LORD BRACADALE: We'll stop for lunch and sit again at 2 o'clock.

(1.01 pm)

(Luncheon adjournment)

(2.03 pm)

LORD BRACADALE: Ms Grahame.

MS GRAHAME: Thank you. Can I just go book to some of the evidence you gave earlier. I just want to clear something up. You have mentioned that you did meet with

PIRC as part of the discussion that we had about meetings with the family and Crown Office and there was a discussion about meeting with PIRC. I had suggested to you there was -- we've heard evidence about one meeting where the meeting with the family was with Kate Frame, who was the Commissioner at the time.

A. Okay, yes.

Q. Do you remember when you met with PIRC?

A. I mean from recollection, it was quite early on.

Q. Do you remember where it was?

A. I believe it was in the offices of Aamer Anwar.

Q. I think we have heard some evidence about a meeting or meetings that have taken place in his offices --

A. Yes.

Q. -- from investigators from PIRC. Were you present at that meeting also?

A. Well, I was certainly present at one or potentially two, I mean aside from the meeting with Frank Mulholland and then with the Crown Office, but that was at their offices.

Q. All right. Thank you.

I would like to move on, please, to go back to 366, if I may, and paragraph 68. 68, please. There we are:

"Inquest has documented how there has been an institutionalised unwillingness to approach deaths in

custody as potential crimes from the outset, resulting in loss of forensic evidence identification of witnesses, and ability to probe police officers' accounts of events."

A. Yes.

Q. I think you have talked about an unwillingness to approach it in that way already today.

A. Yes.

Q. "Families want cases to be dealt with as a disciplinary or criminal investigation from the outset where it appears on the face of it to have been potential disciplinary or criminal offences. They should be entitled to expect that the correct procedural steps are taken to ensure the integrity of those proceedings in the event that prosecutions or disciplinary proceedings are ultimately brought."

And again, from the experience of Inquest, are families interested in not just prosecutions but also in disciplinary processes?

A. I think the answer to that would be that families are wanting accountability where there has been evidence of criminality or wrongdoing which would include both disciplinary or criminal proceedings, which is why it's so vital that the investigation is conducted properly and that it's robust and that it leaves no stone

unturned.

Q. Thank you. And can we look at paragraph 69:

"When it comes to evaluating the actions of police officers, many bereaved families and clients experience a sense of IOPC bias (that would be the equivalent of PIRC) towards the police, particularly where decisions are made from the outset that investigations are not criminal or disciplinary investigations. This perception is in part because some of the IOPC staff are ex-police officers, an issue which is constantly raised by families as being at the heart of their perception of bias and lack of independence. The IOPC structural independence from the police is determined by this lack of cultural independence and this can be manifested in them taking an overly cautious and conservative approach and a lack of robustness and vigour in decision-making when investigating the actions of police officers who are unable to provide a reasonable explanation for their actions. This has been a long-standing issue and one reflected in the Casale Review Home Affairs Select Committee inquiry into the IPCC 2013 and the Angiolini Review."

And when you refer to the Angiolini Review, is that the 2017 Deaths in Custody?

A. Yes, yes.

Q. I'm interested in Inquest's experience of families being concerned about this aspect.
A. I mean that's a long-standing concern which exists to this day and I would suggest, within the context of PIRC, that obviously it's also similar in the sense that the PIRC has a lot of ex-police officers within its -- within its staff team.
Q. And does that undermine the trust and confidence again that families have?
A. I think without doubt. I mean I would say that I think families accept that obviously good investigative skills are crucial and understanding policies and procedures and things, so clearly there is a need for expertise there, but in terms of the rigour with which investigations are carried out and really the willingness and ability to properly probe I think that's something that be found wanting in a lot of the investigations that certainly we've been involved in.
Q. And in 607, your second statement, if we could look at paragraph 35 I think you specifically address this further. Paragraph 35:

"For the 'I can't breathe' report we researched the issue and found that none of the post-death investigation process; [and then you list them] the IOPC; the coroner's context; prevention of future death

reports; the Crown Prosecution Service; meaningfully consider the potential role of racism. We looked at 12 cases of black men that had occurred between 2008 and 2018. We looked at the record of Inquest which sets out the findings and conclusions and not a single record or report mentioned racial discrimination or racism. Only two of the Cause of Inquest and one Prevention of Future Death report had the ethnicity of the black men who died at all."

Is that a reference to them being black?

A. Yes, I mean it was impossible -- from the reading of the reports, you would not know the race or ethnicity of the person who died.

Q. Thank you.

"The result is that the potential role race may have had is entirely absent from the official version of these events."

What impact does that have on families?

A. Well, the reason we did the research was because, as we've already addressed, this has been a thematic area of concern and we had some funding to be able to do a more deep dive into our work and we had been increasingly concerned that, in our view, a lot of these deaths raised serious questions about racial stereotyping or people who died and yet, that was

completely absent from the investigation and inquest process, in fact all of the process.

And in order to be able to do a report to make recommendations, clearly we needed to properly evidence that so there was a significant amount of research that went into looking at those cases in you detail. We also had a reference group of lawyers who were interviewed who had done this work and also families were interviewed. And of course what families said was, well, you know, of course that was in our minds, but we didn't feel confident in raising this as an issue because we were worried we would be accused of playing the race card or we had already experienced hostility and suspicion and this would make us feel -- you know, this would potentially make us be seen as more difficult and so it was -- there was that disconnect between what families thought and then what was -- how the investigations were approaching this.

And I mean it's interesting to note that in one of the cases that I've referenced in the report, you know, even a coroner accepted in a very -- this is in the death of Olaseni Lewis -- the coroner herself, who had not examined the question of race during the course of the inquest, herself acknowledged that race was the elephant in the room. So the reason we did the research

was really to try and evidence the fact that, you know, we felt that race and the question of racial stereotyping and racism should be part and parcel of any investigation that was carried out into the death of somebody from a black or racialised community.

Q. And it should automatically be part of that investigation?

A. Yes, absolutely.

Q. And I think then you do say at 36:

"That renders race and racism invisible. If you don't knowledge something as a problem, as an issue, how can you develop policy interventions and how can you ensure that at the issue is addressed?"

And so is that the -- you consider that without even asking questions about that or addressing that or exploring that line, you can't then identify and acknowledge where that issue is a problem?

A. That's right. And I think, you know, the other observations I would make is I think there has been a kind of institutional denial of racism and of the disproportionality that the report demonstrates. And so we felt that this was something that, you know, if we produced a report that we could then use in our policy work and use in our meetings with the various investigation and oversight bodies and I mean I was also

pleased to see that, you know, obviously we gave evidence, as you've mentioned earlier, about the evidence we gave to the United Nations in their inquiry into law enforcement and people of African descent. And they made a very clear recommendation and, obviously, it's -- you know, this is globally, but they made a very clearly recommendations about the importance of examining the role that racial discrimination, stereotypes and biases may play in law enforcement and accountability processes. And I was pleased to see that, because in any way that absolutely captured for us the essence of what we were trying to do with this report to ensure that it was investigated.

Q. Thank you. And talking the United Nations, could we go back to WIT 87, please, and look at paragraph 59. These we've looked at earlier today. And these are the 2020 submissions to the United Nations and we see here you have also submitted in relation to prosecutions:

"Our monitoring shows that since 1990 that there have been nine unlawful killing conclusions returned by juries at inquests into deaths involving the police and one unlawful killing finding recorded by a public inquiry into a police shooting, as well as other findings critical of force used. Yet none of these have resulted in a successful murder or manslaughter

prosecution. Indeed, we are not aware of a single occasion when the police have been successfully prosecuted for manslaughter at an individual or corporate level."

And I'm interested in this comment, was this more research that Inquest did?

A. I mean this is something that we do as a matter of course. We monitor inquest outcomes from our work and then what happens -- what happens to them. Just bear in mind this was December 2020 and since then there was the successful prosecution of a police officer following the death of Dalian Atkinson, which is in one of my subsequent statements.

But I mean absolutely and I think, you know, it's one of the reasons why we've talked about kind of, you know, immunity and impunity within the system, because even where there has been the most overwhelming evidence of dangerous or excessive use of force, and juries have reached conclusions which were then on the criminal standard of proof, we've then not seen the corresponding action, you know, either criminal or indeed in many causes disciplinary.

Q. I see.

A. And I think just to add to that and, you know, going back to what that does to families' confidence, I mean

it's fair to say I think that this as an issue that has really undermined both family confidence, but also community confidence in the processes that we have for holding the police to account. Because on paper, you know, we have a relatively sophisticated framework, but in reality the question as to whether or not it's achieving accountability and change is something that is not borne out by a lot of the work.

And in fact, you know, it's very often families and families engaging in campaigning that really draw these issues to public and parliamentary attention and I think, you know, utilising the United Nations was important to us because we were, you know, able to use our experience in the UK to help try and develop best practice, you know, globally.

Q. I was going to come on to the issue of misconduct proceedings actually. You have obviously explained the situation regarding prosecution, but am I correct to understand your evidence that you've also seen a failure or a lack of misconduct proceedings being taken against officers, even where there have been findings of unlawful killing?

A. Yes.

Q. Or excessive force having been used?

A. Yes.

Q. And are you aware from your experience why there are no subsequent misconduct proceedings?

A. I mean I've said earlier on that there are lawyers who could probably better answer that question, but certainly, you know, the other issue that we've seen is officers, you know, retiring or leaving the force before action can be taken and you can only imagine what that does to families, but also just the way in which these processes are so long and drawn out that I think the lack of rigour which I've talked about previously in regard to the investigations is also subsequently revealed through the lack of the misconduct processes.

Q. We've heard some evidence impact of retirement or officers leaving before misconduct proceedings can be concluded. Is that the position in England and Wales that officers can retire or leave before misconduct proceedings are concluded?

A. It certainly was. My understanding is that the system has been changed now so -- but I think one of the concerns that certainly families have had is that even when these processes, you know, are ongoing that the sanctions at the end are very often what are called words of advice and it's very rare to see police officers sacked as a direct result of -- certainly in the context of deaths in custody.

Q. Right. Can I ask you where an institution such as a police service, police force, or Crown Office in Scotland, have been found to be institutionally racist or have admitted that they are institutionally racist, I'm wondering on whether you have any concerns about those organisations considering issues of conduct in relation to staff themselves? Obviously, I'm considering the question of independence, and I wonder if you have any concerns about that matter?

A. Yes, my understanding -- can you just explain the question again.

Q. Yes. Sorry my fault.

A. No, no.

Q. We've heard evidence that Police Scotland's Chief Constable last year admitted Police Scotland were institutionally racist. We've also heard evidence that as a result of a report, the Jandoo Report, and incidents in relation to Chhokar and the murder of Mr Chhokar, that Crown Office at that time were considered institutionally racist.

A. Yes.

Q. And I'm interested from the perspective of considering conduct and misconduct matters, to what extent Inquest or yourself have any concerns about organisations which have admitted or been found to be institutionally racist

are in charge of looking at conduct issues for their staff?

A. I mean I think the short answer is, yes. And of course, you know, there is expert evidence that could be adduced to assist in that role.

Q. Where would that be from?

A. Well, from people who -- I mean I think there's a systematic problem about how organisations, and I'm thinking about the IOPC as it now is, in terms of their own ability to investigate race and racism and the fact that there are people who, you know, there are plenty of academics who have written, you know, extremely important research around, you know, how racism, be that, you know, institutional, systematic, structural, manifests itself and who would be in a good position to be able to offer expert advice about how one investigates that.

And I think if you look at the Sylvia Casale reinvestigation into the death of Sean Rigg, you know, I thought that that could and should have been a bit of a turning point for the IPCC, because she was very clear in that investigation, that reinvestigation, how the question of race just simply wasn't looked at. And, you know, that could have been a really important, you know, learning opportunity for that, you know, that

organisation, but one in my view that they failed to grasp.

So I would say of course, you know, there is a problem about, you know, if you're an organisation that -- I mean I welcome the fact that the Chief Constable actually came and gave evidence to that effect, because certainly that's not something that has been repeated in England and Wales, not least with the Metropolitan Police Commissioner, and so I think that's an important step forward, but it's all very well accepting that. It's a question of how does that then change culture and practice within the institution itself.

And, you know, I would say suggest that if you're really, really committed to cultural and practice change, then you need to also get help in helping to drive that by people who understand what we mean by "institutional racism" and "structural racism" and how that impacts on the way in which police officers behave, at an individual, but also at a corporate level.

Q. And would Inquest see a role, specifically in Article 2 cases, where there have been deaths --

A. Yes.

Q. -- of black men in particular in relation to considering issues of the conduct of officers in a situation along

those lines, would Inquest see a role for perhaps an independent investigation into things like misconduct?

A. Yes.

Q. Can I ask you to -- we've been talking about post-incident management and issues regarding that. Can I ask you to look at paragraph 90 of your first statement, which is the 366 statement, paragraph 90.

Now, this covers three pages and I don't intend to go through every single line, but this section sets out in some detail what, as I understand it, Inquest would consider to secure a meaningful investigation.

A. Yes.

Q. And it reflects what families would be looking for; is that fair?

A. I would suggest it reflects what families, Inquest and the lawyers that we've worked with over these decades have sought to try and achieve from these processes.

Q. Thank you. And can we move on to D, first of all, which is the fourth. Yes:

"To be trusted to receive information on a confidential basis so that matters can be shared with them as the investigation progresses and key documents, such as body-worn footage, CCTV, can be disclosed. Many families are told that disclosure of key materials cannot be provided, although no family members is

witness to the events covered by the investigation, simply because there is the potential for a criminal process and many families have to battle to receive disclosure throughout the process."

A. Yes.

Q. Could you expand on why this is one of your suggestions for best practice?

A. I mean because I think one of the worst things for a family is the kind of drip feed of information that they get as part of the investigation, not least when it takes a long time, and that there are processes that can be put in place so that they can actually have some of those documents, you know, respecting the fact that, you know, there is confidentiality and that they --

I think if families have information explained to them, then they are perfectly able to understand the need for confidentiality, for the fact that this is information that will be shared with them on the understanding that it is -- it is -- it is being seen by them alone and they can't talk about it. And many of the families, you know, that I work with that happens to.

But I think it's important to feel, you know, if you want to feel part of a process that you're given access to that information and too many families have to

actually, you know, fight for that information as the investigation goes on. And, you know, I would suggest that, you know, if a family are properly legally represented then their lawyer can help guide that process and, you know, ensure that, you know, I don't know footage is seen within their offices and, you know, it's not shared et cetera so.

But it's -- it's terribly important, because I think, you know, for many people, you know, as I have said, you know, the worst thing has happened and not having that information, you know, it creates -- it creates a lot of trauma and it can actually assist them to begin to understand what happened, but also respect the integrity of the investigation that is being carried out.

Q. And again, does that help to build the trust and confidence?

A. Yes, absolutely.

Q. And you then say, "Many families have to battle to receive disclosure." We've heard evidence from Professor Meer and he talked about families having to litigate or do FOI requests or that type of thing. Is that -- do Inquest have experience of that when you say "battle to receive disclosure"?

A. I suppose when I use -- I mean unfortunately for many

families it does feel like a battle and it feels like a very unequal playing field when, you know, you're a bereaved family and you have your lawyer and, you know, your -- I mean we only really need to look around this Inquiry room to get a sense of the interested parties that often are involved when these deaths happen. And so it's quite often the drip feed of information or families at the outset giving very important information to the investigators and then, for whatever reason, that information not being seized, like important CCTV footage. We've talked about, you know, body-worn footage, which is obviously more relevant down south. And I think, you know, families with a lawyer struggle, so goodness knows what it's like for a family who don't have access to legal representation.

Q. Thank you. Could we look at F now, please:

"Cases to be dealt with as a disciplinary or criminal investigation from the outset where there appear on the face of it to have been potential disciplinary or criminal offences, and that the relevant procedural safeguards are put in place to ensure the integrity of the investigation overall. Families feel strongly that a level playing field requires police officers to be treated as a civilian would if there are grounds to suspect that they have been responsible for a

crime, or as they would be treated in a place of work if there were potential serious misconduct and they naturally compare the process with how a civilian would be treated."

Again, is this a theme that you have become aware of through work with Inquest --

A. Yes.

Q. -- about the reaction of families?

A. Yes.

Q. I think you said earlier that there may be a perception, if I can summarise it this way, that police officers are given preferential treatment.

A. Yes, and that they're above the law. That's how it's perceived and, you know, going back to the earlier observation about what happens from these processes, it's also borne out in the reality in terms of lack of the prosecutions or indeed lack of disciplinary action.

Q. Thank you. And although the Chair will be able to read all these items, I just like to now turn to G for golf, the seventh one, which begins:

"Independent investigations and coroners should ensure they meaningfully consider the role and impact of race/ethnicity of any black and/or racialised person who dies following police contact examining the potential role of racism or discrimination from the outset,

including in the terms of reference and through to the scope of the inquest and inquiry."

And I think you have said that already?

A. Yes.

Q. You would like to see that automatically included?

A. Yes.

Q. Particularly where there has been a death of a black man?

A. Yes.

Q. Yes. Thank you. Could I ask some questions about family liaison officers now?

A. Yes.

Q. If we go back to your original statement, the 366, and if we could start at paragraph 39.

Now, you have given a significantly detailed explanation in relation to FLOs and I won't go through every line, but I'll dip into some of this, if I may. I think in 39, when that's on the screen, halfway down you say:

"This role has not translated well."

Do you see that?

A. Yes.

Q. "... for those families who have been bereaved following police contact. Alongside their support role, the FLO is also an investigator and an evidence gatherer.

Families are not always aware of this and so tensions can arise when families perceive a lack of transparency. The FLO role is often confusing and, at worst, intrusive."

Could you help the Chair understand some of the difficulties that families who Inquest have been supporting, some of the difficulties they've experienced?

A. I mean I think I say earlier on that the FLO role is well-established to support victims of crime and, of course, it's important to say here that the families that we work with are not seen as victims of crime and that results in a number of issues, not least they're not -- they don't get the provisions of, for example, victim support or for automatic counselling et cetera.

And the FLO role has -- when I say it's not translated well, it's particularly around the investigation and evidence gathering role that they perform along with the investigation body, be that the IOPC, IPCC or indeed the PIRC. And what families have reported, and I think I might have given some quotes somewhere about this, is that they have felt that they are the subject of investigation and that the FLO has been trying to get information from them about their loved one to report back to the investigation, rather

than the way that sometimes the FLO role is presented, which is there to advise and support and I think that that's -- I think that that causes real tension.

And families have reported being, you know, being felt like they were being spied upon and I think that's a real perception. And however good the FLO may be, at the end of the day, they are part of the investigation process. They are not there to carry out an independent role in terms of, you know, the family's advice and support person and you know -- I distinguish that between the role of the FLO in other situations where that role can be extremely helpful for families when they have had an experience or a death or -- so it is about -- it is about the fact that, at the end of the day, the FLO is part and parcel of the investigation that's being carried out.

Q. And so is this a particular difficulty in situations where there has been a death following police contact where it's an Article 2 situation?

A. Yes, I'm talking about the role of the FLO following deaths in custody and Article 2 cases, absolutely.

Q. Thank you. And then if we turn to paragraph 46, please, you also mention the -- and I'm halfway down this paragraph:

"They also need to understand and recognise family

dynamics and that often the responsibility for informing other family members on progress falls to an individual."

I'm interested in that aspect, this idea that it can fall to an individual. What pressure does that put on that individual member?

A. I mean it's -- I think it's extremely difficult to be in the situation where you are, I suppose, the go-to family member who has to report on progress of, you know, investigations, inquests whatever it might be, at a time when you're also trying to navigate the processes yourself. I mean the emotional toll is absolutely huge, and I think that it places just a lot of pressure on people and I mean I have seen it, I have seen it for 30 years on -- you know, it's very often there will be individual family members who have effectively kind of drive those processes for the benefit of all family members and it takes -- it takes a toll.

And that's not least the fact that, you know, quite often they have had to actually, you know, fight to understand what their rights in the process are and, you know, I have already described the kind of information deficit that often follows these deaths and how difficult it is to get access to advice and support.

Q. Thank you.

And again, I would like to some to the best practice section of this statement and this is at paragraph 52, sorry. There we are and it says:

"The following is a summary of the key points of best practice in respect of FLOs."

And again, is this gathered together from experience from Inquest?

A. Yes.

Q. Comments from families and lawyers who are involved?

A. Yes.

Q. Now, so you talk about:

"A. Clarity from at the outset.

"B. Signposting to independent advice and support.

"C. All families should be advised of their rights to legal advice and representation."

You talk about, at the bottom of the page, written and oral information about support services being provided to families.

And then D:

"Refer the family to Inquest at the earliest opportunity.

"E. Training from a trauma informed approach."

A. Hm-hmm.

Q. And F:

"Clear protocols for the structure of the

relationship.

"G. Bereaved people should be treated with dignity and respect, empathy and compassion and the consideration that any bereaved person should expect."

This -- tell me if you disagree, this seems to mirror some of the comments made by Macpherson in the Stephen Lawrence Inquiry. We have heard evidence about bereaved people should be treated with dignity and compassion and respect.

A. Yes, and I mean it's also I think spelled out very clearly in the Angiolini Review. And just while you were saying that, I was just thinking your earlier point about the responsibility lying on one individual. I think the other issue is that, you know, because these investigation processes, as we know, are protracted, families wait for -- you know, they're told that on certain dates information will be forthcoming or decisions will be made and so families wait for those phone calls or for that information to come, and I don't think people realise what it's like if that phone doesn't ring or if that information is not forthcoming and how that makes people feel, not least if you are the person who everybody else is relying on to explain what is happening.

And I say that because I remember a conversation we

had with the DPP, the Crown Prosecution Service, about this and trying to get them to understand that, you know, if you agree to give families an update, you give them an update, regardless if there's nothing to report. Sorry, that was a clumsy sentence.

Q. You make contact with the family?

A. You make contact with the family regardless, because otherwise families are just waiting bereft of information and it's better just to have that contact, even if there's nothing to say.

Q. Yes. All right. And you mentioned the word "recommendations". As I understand your statements, without taking you to any particular passages, you take the view that there are issues about recommendations of reports and things that may be are not being done and I think a part of your second statement, 607, if we could go back to that, you talk about the National Oversight Mechanism?

A. Yes.

Q. And you would like to move on to that, please, and ask you some questions about that. So paragraphs 147 and 148. Sorry, I have maybe -- well, we can start with 147:

"The lack of a statutory duty of candour is also relevant."

And you talk about the Hillsborough Law and "It's so important to it applies to all law enforcement agencies", but actually it was the National Oversight Mechanism that I was coming on to and that's 148, and if we can look at that, please:

"I am asked to explain why Inquest are campaigning for the introduction of a National Oversight Mechanism to monitor the implementation of recommendations arising from deaths involving the state.

"149. Prior to coming up with this proposal for an independent body to be set up, we met with bereaved families, lawyers, civil society, academics, policy experts, and oversight and monitoring bodies. We also met with the Independent Advisory Panel on Deaths in Custody of which I was a member."

Was that the cross party --

A. That's the cross-government sponsored.

Q. Right. Now, I wonder if you can assist the Chair by perhaps explaining a little about the context here, how this suggestion arose?

A. Yes. I mean maybe I'll start just by talking about it in the context of restraint-related deaths just by way of example, because what your Inquiry will have realised, not least by some of the information that Inquest have provided and others, is that this is not an

under-researched area. There have been investigations, inquests, independent government-commissioned reviews, academic research et cetera, all making successive recommendations about action that could be taken to try and effect policy and practice change.

And I think for me one of the biggest frustrations about Inquest's work is seeing the same issues being repeated across our work both in the context of deaths in custody and detention, but also even if you're looking at other areas like Hillsborough, Grenfell, the Infected Blood Inquiry, where we have seen recommendations made and you always see the State's organisation saying that lessons will be learned, that action will be taken and what has become very clear is that there is no independent body that is responsible for monitoring, analysing, and following up on action that has been taken. So it's very often families who have been the drivers for change following their loved one's death or following inquests or indeed something like the Angiolini Review, which we can come on to.

I think what happens is that too often the recommendations, which potentially are lifesaving recommendations, that's the whole point of them, they are about preventing deaths happening in the future, you will sometimes see some initial work and initiatives and

the commitment by some people, but of course people move on and organisations do not have good memories, good knowledge. And so what tends to happen is that the deaths, the recommendations following deaths just disappear into the ether or sit on a shelf and then only come out when maybe, you know, a parliamentarian asks a difficult question.

And so our proposal is about trying to ensure that there is that proper oversight of recommendations, which we see as being important for anybody concerned with State-related deaths and their investigation and, importantly, their prevention.

Q. So filling that black hole where recommendations are made, but then no body working at, as you say, monitoring, analysing or following up recommendations, those recommendations designed to prevent deaths in the future?

A. Yes, and I mean I think -- just to add to that, I think there's also a really important human rights case for establishing this, because we have talked about Article 2. Well, the Article 2 obligation is not just to investigate, but it's about learning lessons for the future.

And you know, I recently gave evidence to a House of Lords Inquiry into the Inquiries Act and, you know, I

know members of the House of Lords are quite shocked to discover that this doesn't actually exist. And you know, in the context of inquests, but also public inquiries, you may have -- you may have a parliamentary committee that might look at one aspect of a public inquiry, but that's not sustained, and I think one of the really important things about an independent oversight mechanism is to make sure that there is a constant following up and reviewing of what action is actually being taken, you know, on the ground to -- so that there is a much more rigorous process to ensure that these recommendations that have come out of inquiries, often when the worst possible thing has happened or have come out of inquiries because of serious concerns about the conduct of government or government organisations, that there is a real opportunity to learn and to maximise that preventative potential that inquiries, inquests, fatal accident inquiries can actually perform.

Q. Thank you. Can I move on to something else now. We looked earlier at "I can't breathe", the report, and that was SBPI 0607. Sorry, that's your -- well, if we look at your statement first of all, 607, and we look at paragraph 27. And you say here:

"We recently produced an evidence-based report

called 'I can't breathe'. On paper, gland and Wales have a highly developed system of oversight of police conduct with provision for identifying racism and a well-established investigation and coronial system to examine the circumstances of deaths in state custody for the state to be accountable. However, we were aware that the lethal pattern of disproportionality continues and that no death of a black person following police custody or contact has led to officers being effectively disciplined for racism or held to account."

And that's subject to the comment you made about Mr Atkinson's death and the criminal trial that resulted:

"This was also despite the recommendation in the Angiolini Review that the police watchdog investigators should consider if discriminatory attitudes have played a part in all cases where restraint, ethnicity and mental health play a part. One of the things that we had documented in our work was how race was the elephant in the room. It was invisiblised, erased from the official narratives about death, because it was never investigated as part of the investigations that followed the deaths of through the Inquest hearing."

And I would like to look next at paragraph 38 and this contains your recommendations --

A. Hm-hmm.
Q. -- for "I can't breathe".
Now, I would plan to simply go through your statement on this, although we do also have the report itself at 513. If you feel that would be inappropriate to use your statement --
A. Yes.
Q. I can use your statement. Thank you so much.
A. Yes.
Q. So let's look at paragraph 38:
"The other recommendations in the 'I can't breathe' report are as follows:
"Post-death investigations and scrutiny.
"A. 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 integral and a proactive part of their work ... This in turn should be central to the work of the Crown Prosecution Service in their response to these deaths."
And so again, does this follow on from what you said earlier?
A. Yes.

Q. About it should essentially be automatically included --
A. Yes.
Q. -- as part of a proper investigation, an adequate investigation into deaths in custody?
A. Yes.
Q. Thank you. And then if we can move on, please:

"b. 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."

And would this be equally equivalent to PIRC investigators?

A. Yes.
Q. And so an alignment, if you like, between the civil approach and an approach taken in relation to actual criminal investigations?
A. And this is the matter -- I mean this -- I think I said this earlier, but this was a report that also engaged with, I believe, 12 of our Inquest lawyers group members who have got particular expertise in working around these cases and so, you know, and also had experience of

the Equality Act.

Q. Thank you.

"c. 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.

"d. In the context of Scotland these recommendations and the findings of this report more broadly should be considered by PIRC, the Crown Office and in relation to fatal accident inquiries."

A. Yes.

Q. Then "Inspectorate and monitoring bodies", if we can move up the page:

"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."

And then "The treatment of Black people by the police", one of the recommendations was to:

"... call on the UK Government, the Home Office and national police forces to make a time-bound public commitment to end the deaths, the 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."

A. Yes.

Q. Sorry, yes. Sorry, I lost my place there. I think there was one called "Restraint", yes:

"We call on the government to implement the unfulfilled recommendations of the Angiolini Review (2017) [the deaths in custody] with a particular focus on recommendations relating to the use of force and restraint."

A. Yes.

Q. You mentioned mental health.

A. Yes.

Q. And you talk about -- specifically about de-escalation and care being the focus?

A. Yes.

Q. I:

"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 an aim of creating nationally available systems which put community services and specialist health care practitioners at the centre of

crisis responses without police."

And then -- keep going, you then turn to "data". And here you talk of the IOPC:

"... to monitor and publish data on restraint-related deaths both in police custody and deaths following police contact, disaggregated by ethnicity and other protected characteristics."

A. Yes.

Q. And following on from that you deal with "Duty of candour". We have heard some evidence about that and we understand there's a bill going through the Scottish Parliament in relation to matters connected with that and other issues.

"Access to Justice":

"The Government, coroners' service and IOPC should enact the outstanding recommendations of the Angiolini Review around family support and the coronial system."

"National Oversight Mechanism", so this is a specific recommendation regarding what you have explained to the Chair that the government should:

"... establish a new and independent body tasked with the duty to collate, analyse and monitor learning and implementation arising out of ... investigations in inquiries."

A. Yes.
Q. "Transformative social change," to decrease reliance on policing and investment in the criminal justice system.
A. Hm-hmm.
Q. And then in your inquiry you then talk about specific comparisons with Scotland and England.
A. Yes.
Q. I only have one or two minor matters to deal with, but I'm conscious that the time is drawing to when we normally have a break, but I think I have got one issue I could perhaps deal with now.
A. Okay, yes.
Q. And this relates to publications for families. And I wonder if you could look, please, for me at SBPI 00515, which I understand is a guidance document, 00515, "Achieving racial justice at inquests. A practitioners' guide."
A. Yes.
Q. Am I right in saying this is a document which provides guidance that inquests have prepared along with Justice?
A. Yes, the human rights charity Justice.
Q. Yes.
A. They approached us a while back when we were doing our research into the report "I can't breathe" and they were interested in looking at this issue in more detail, so a

working group was set up chaired by one of our Inquest lawyers, Leslie Thomas KC. The working group included lawyers representing the State as well as family lawyers, academics, family member, and, obviously, Inquest and Justice and it was very much -- it's very much I think best described as a bit of a toolkit for those conducting investigations, inquests and I would argue its relevance of course in Scotland.

And I was very pleased that we got the -- we got the active support and support of the Chief Coroner's Office in doing this and we're already seeing that it's having an impact in the way in which some investigations are being conducted but -- so I think it's really very much a kind of blueprint of good practice. And the idea behind it was that it provides not only the broader context on why it is we should be looking at this issue in a broader context, it's also kind of gives everybody involved, you know, whoever they are, investigators, coroners, a kind of an opportunity to get a sense of how and why they might approach these issues within investigations.

Q. Who gets these documents or brochures, guidance, who gets this?

A. It's a report --

Q. It's a report.

A. -- effectively. So we had a launch of it. We've disseminated it. Well, Inquest and Justice have disseminated it and we're hoping that the Chief Coroner will consider in their next round of training for coroners, mandatory training for coroners, that they will have a session on the report during that training, but it's very much up to us to try and, you know, drive that change, but I think it's -- I think it's -- it's a helpful -- it's a helpful document for people.

Q. And does this help those working within at least the coronial system, if not further beyond, to understand perhaps steps that can be taken during that investigation, that part of the process --

A. It's for anybody.

Q. -- regarding race?

A. Sorry, to cut across you.

Q. No, not at all.

A. It's for anybody who's involved in investigations and inquests. I mean I would say it has a relevance across the UK and more broadly. To be perfectly honest, that was the point behind. It was to assist people in their roles.

Q. Thank you. I'm conscious that it's now 3 o'clock, would that be an appropriate time?

LORD BRACADALE: We'll take a 15-minute break.

(3.01 pm)

(A short adjournment)

(3.18 pm)

LORD BRACADALE: Ms Grahame.

MS GRAHAME: Thank you. I would like to now turn on your second statement to paragraph 116. And this deals with the final matter that I would like to address with you today. So this is SBPI 00607, and it's paragraph 116 towards the end. And you'll see that this is under a topic called "Restraint".

A. Yes.

Q. And if I can read from the third line:

"A pattern what we've seen time and again..."

Do you see that, line 3 at the end, "A pattern that we have seen time and again"? Have you got that there?

"... and I think it's really evident and looking at Sheku's death is that default of police officers to a situation is to go in and restrain and use force, whether that is the use of batons, CS spray, or hands-on restraint, rather than stepping back, de-escalation, containing. That response aggravates and exacerbates the situation. It increases the risk of harm to that individual because somebody who is in a state of agitation is often very scared, very frightened and so a rational response to fear and to restriction of oxygen

is to struggle to breathe. The mechanics of a restraint death is such that that can be fatal. There is a video called '60 Seconds to Save a Life' which was published precisely to address how fatal restraint can be."

Now, am I understanding correctly that after the Angiolini Death in Custody Report in 2017 there was a concern expressed in relation to some of the findings?

A. Yes.

Q. And a decision was taken to launch a video to help police officers recognise a medical emergency in custody and act quickly to resolve it; is that correct?

A. Yes, I think the video though was to show precisely how quickly restraint can become a medical emergency and how quickly somebody can actually die. That was the thinking behind it.

Q. And do you remember the bodies that were involved in preparing this video?

A. From recollection, it was a bit difficult to actually find from the -- because it was on YouTube, but I believe at the time it was the College of Policing and the National Police Chiefs' Council --

Q. Right.

A. -- who were behind the making of the video.

Q. And they combine and created this video to provide assistance to police officers --

A. Yes.
Q. -- perhaps to be perhaps used for train training purposes?
A. Yes.
Q. I would like to play this video now. It's very brief. It's a minute --
A. 60 seconds.
Q. A minute and a few seconds. And I would like to play that if that is possible and what we'll do is, we'll watch it and then I'll ask you one or two questions.

(Video playing)

Q. So was this a video that from Inquest's perspective you would like to see that type of training being given to police officers to emphasise the speed at which restraint -- restraint we've heard is a risk, there can be risk of death. But is that the type of thing that you would like to see in terms of emphasising the speed at which these things can occur?
A. Yes, I mean I guess, you know, a frustration is that we've had various initiatives previously. I mean I recall, and again it's in my statement, you know, following the death of Roger Sylvester, who was a black man who died following restraint, there was a review by the Metropolitan Police and then there was guidance and kind of warnings about the dangers of positional

asphyxia, particularly about at the dangers of prone restraint.

And I think, you know, I would be very interested to know how many new police officers have seen this particular video and I think it goes back to my earlier point about, you know, initiatives that follow high-profile deaths, which of course I welcome, but, you know, how do we ensure that this information is actually embodied in policy and practice on the ground? And how do we ensure that where restraint is taking place that that -- that where there is body-worn footage, for example, that, you know, senior police officers are actually reviewing that to check how, you know, how restraint is being carried out.

I know in the Angiolini Review we made recommendations about training involving bereaved people and certainly myself and, in fact, Marcia Rigg, who you're hearing from, but also the family of James Herbert, we have addressed police conferences about our work, but also about the concerns that led to the deaths of their relatives. And I know from the police officers involved how important that was to hear that perspective and, you know, it was -- it was I think a way of actually talking about these issues in -- in a way that people could identify with that the family

member before them, who was there because, you know, they wanted to try and not only explain the personal impact of having a relative die in those circumstances, but about trying to help people understand the risks and how, you know, change, you know, how to drive the change that they wanted to see as a result of this.

But, you know, as I say, I mean, you know, I have done this work for a very long time and, sadly, what I see is that positive initiatives often just get forgotten, because there isn't that kind of institutional knowledge.

Q. We've heard some evidence about institutional memory loss.

A. Yes.

Q. When people, as you said before the break, leave a role, move on, get promoted?

A. Yes.

Q. And that that can -- the impetus the drive forward can be left.

A. And, you know, I have to -- I have to knowledge here that the, you know, the vital contribution that families have played to try to drive that change, you know, often, you know, putting their own lives on hold, because, you know, they're so committed to try and see things changing so that other people don't end up in the

same situation that they have. And in fact, you know, I mean one can argue that, you know, you know, individual prosecutions in these cases, you know, might be one form of accountability, but, you know, for families another form of justice and accountability is to actually see things change so that other people don't die in similar circumstances, you know.

And as I said in my earlier evidence, this is not an area that has been under-researched. There are numerous documents and guidance and recommendations about the dangers of restraint and the fact that we're still talking about, you know, that the fact that these deaths are not just historic, but they're current is for me, you know, kind of illustrates the systematic problem that exists.

Q. And so is it your fear that lessons are simply not being learned, despite all the recommendations and reviews and inquiries?

A. Absolutely.

Q. And so although individual initiatives, such as the "60 Seconds" video are very positive and welcome, the key then, if I can sum up what you have said, is there must be following through on the recommendations, monitoring the recommendations and actually seeing change implemented on the ground?

A. Yes, and holding people to account for that. And that is not just about individual officers, this is also about, you know, senior management, because, you know, ultimately, you know, they are accountable for making sure that their organisations are, you know, acting on life, you know, potentially lifesaving recommendations. And it's not like the warnings aren't out there about the risks of restraint and, you know, I think we are -- we are definitely at a place where everybody is aware that restraint in and of itself can be fatal.

Q. Thank you. Could you give me a moment, please.

A. Yes.

Q. Thank you very much. I have no further questions.

LORD BRACADALE: Are there any other Rule 9 applications?

Ms Coles, thank you very much for coming to give evidence to the Inquiry. I'm very grateful for the time you've taken in preparing for that in addition.

We're going to adjourn now and you'll then be free to go.

A. Okay, thank you.

LORD BRACADALE: Inquiry will adjourn until tomorrow at 10 o'clock.

(3.30 pm)

(The hearing was adjourned to 10.00 am on Friday, 27 June 2024 day)

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