1 Thursday, 4 July 2024
2 (10.05 am)
3 LORD BRACADALE: Good morning, Ms Rigg. Would you raise
4 your hand and say the words of the oath after me.
5 MARCIA RIGG (sworn)
6 LORD BRACADALE: Ms Thomson.
7 Examination-in-chief MS THOMSON
8 MS THOMSON: Good morning. You're Marcia Rigg.
9 A. I am.
10 Q. And you were born in 1964?
11 A. Yes.
12 Q. You were the sister of Sean Rigg who died in police
13 custody after being restrained on 21 August in 2008?
14 A. Yes.
15 Q. Ms Rigg, can I ask you to open up the blue folder that's
16 in front of you. There are a number of documents in
17 there and I'm hoping that the first in the bundle will
18 be a statement that you gave to the Inquiry. It has the
19 reference number SBPI 00630. We'll bring it up on the
20 screen in front of you, but some people prefer a hard
21 copy and so it's in the folder if you prefer to work
22 with paper.
23 So this is your statement and if we scroll down,
24 we'll see that you gave your statement on 21 and 22 May
25 of this year. And if we go to the very bottom of your

1 statement, I think it's 60 or 61 pages long, at the very
2 bottom, we will see that you signed your statement on
3 14 June. Now, on the screen your signature has been
4 blacked out, but I'm hoping that your signature will
5 appear in the hard copy that's in front of you?
6 A. Yes.
7 Q. If we can look at the very last paragraph in your
8 statement, it reads:
9 "I believe the facts stated in this witness
10 statement are true. I understand that this statement
11 may form part of the evidence before the Inquiry and be
12 published on the Inquiry's website."
13 So when you gave your statement, when you signed
14 your statement, you did so knowing that it would become
15 part of the evidence before the Inquiry?
16 A. Yes.
17 Q. And did you do your best to give truthful and accurate
18 responses to the questions that you were asked?
19 A. Yes, I did.
20 Q. Also in the folder, and we don't need these on screen
21 just now, but let's just check that you have got hard
22 copies in front of you, there should be three reports.
23 There should a copy of the IPCC's report, and a copy of
24 the verdict of the Inquest jury, and a copy of the
25 Casale Report.

1 A. Yes.

2 Q. At various points during your evidence I will take you
3 to paragraphs within those reports, they'll come up on
4 the screen in front of us, but, again, they're there in
5 hard copy in case you prefer to work with hard copy.
6 You can dip into any of these documents at any time if
7 you would find that helpful when you're giving your
8 evidence and if there's anything that you would like to
9 be shown on the screen, please just let me know.

10 A. Thank you.

11 Q. Before I ask you any questions, Ms Rigg, I understand
12 that you sought permission from the Chair to address the
13 families of Sheku Bayoh and that permission has been
14 granted, so you're welcome to speak to the families now.

15 A. Thank you.

16 I sit here in solidarity with you and other
17 families. I appreciate and respect your tenacity and
18 your hard work to bring this Inquiry to the forefront of
19 this injustice. I respect you, I love you and I send my
20 condolences to the family. More power to you and never
21 give up.

22 Thank you for having me here to speak at this very
23 important inquiry. Thank you.

24 Q. I wondered, Ms Rigg, if you might like to tell us a
25 little bit about your brother Sean, the person he was

1 and when he meant to you.
2 A. Yes. Sean was my brother. He was in the middle of the
3 family, the second brother, and he was charming, he was
4 handsome. You know, he was loved by many and, sadly, he
5 suffered with mental health the last 20 years of his
6 life, but that didn't stop him from doing the work that
7 he did. He was a musician, he was well travelled and,
8 you know, he was a nice guy, he was my brother, and I
9 miss him.
10 Q. Thank you. Ms Rigg, to give some context to your
11 evidence, and for the benefit of any members of the
12 public who might be watching today who won't as yet have
13 seen your statement, it will be published on our website
14 later today, I would like to take you to paragraphs 2, 3
15 and 4 of your statement which summarise the events of
16 the evening that you lost your brother and I wondered
17 whether you might like to read those paragraphs rather
18 than me?
19 A. Yes, please. Paragraphs 2, 3 and 4?
20 Q. 2, 3 and 4.
21 A. Yes.
22 "My brother, Sean Rigg, died in police custody on
23 21 August 2008 following a mental health crisis. I will
24 first summarise about what happened to my brother on the
25 night he died. To give some context to the reader, Sean

1 suffered with mental health issues for 20 years but
2 lived an independent life when well, a talented
3 musician, healthy and likable man. He was just 40 years
4 old. He was not a criminal and did not take drugs.
5 I was his primary carer as his eldest sibling. Sean was
6 living in assisted accommodation, a hostel in Brixton,
7 South London at the time of his death. On 21 August the
8 staff there were extremely concerned about his psychotic
9 behaviour and deteriorating mental health. He had
10 relapsed because he was overdue his medication by two
11 months. Staff made several desperate 999 calls over a
12 period of about three hours to the police asking for
13 them to attend the hostel to take Sean to a place of
14 safety, a hospital, as he was vulnerable and extremely
15 unwell. His name and mental health condition was given
16 to the call handler and the police CAD record was
17 opened. Police refused to attend saying it was not a
18 police matter. Sean eventually left the hostel at about
19 7.60 pm and went out into the streets actively
20 psychotic. It was blatantly obvious that he needed
21 urgent medical assistance and care. Members of the
22 public saw that he was unwell and called the police too.
23 He was dressed inappropriately, naked from the waist up,
24 erratic, doing martial art kicks towards the public and
25 walking in and out of traffic. These were clear

1 indications of a mental health crisis.
2 "Sean was subsequently detained and handcuffed to
3 the rear by four Metropolitan Police officers at about
4 7.40 pm for a public order offence, alleged assault on a
5 police officer and theft of his own cancelled passport,
6 claiming that he did not think the photo looked like the
7 man detained. No checks were made. No checks were made
8 for the passport by any of the officers. The
9 handcuffing took about 30 seconds. He was searched and
10 restrained face down throughout in the prone position
11 using unsuitable and unnecessary force for seven to
12 eight minutes whilst one officer pinned down his legs
13 and the other at the top of his shoulders near his neck.
14 A witness took two photos of the restraint on her mobile
15 phone while looking out of her windows. Multiple
16 witnesses say Sean was struggling, but was not
17 resisting. He was eventually brought to his feet and
18 assisted to the back of a perspex caged police van where
19 the officers say that from the seat he slipped down into
20 the footwell of the cramped cage, still restrained with
21 handcuffs to the rear, and was allegedly on his back or
22 bottom spinning 360 degrees whilst walking his feet
23 around the caged wall. This action sounds implausible.
24 He was then driven at speed on blues and twos to Brixton
25 Police Station, not a nearby hospital. They arrived at

1 the station at 7.53 pm. Sean was kept in the van due to
2 the arresting officer's claim that Sean was violent and
3 had kicked off inside the van. The custody suite was
4 subsequently cleared at the request of the sergeant who
5 said that the custody suite was busy and that a violent
6 man was coming in. The sergeant also claimed that he
7 went outside to the van and looked at Sean directly into
8 his eyes and Sean was just staring, that he was sitting
9 up on the seat with his head leaned on the left
10 shoulder. He shouted at Sean, but he did not respond
11 and that he had no concerns with Sean's health. CCTV
12 proved that this was not true and his account was a
13 complete fantasy. After about 11 minutes Sean was
14 removed from the van in a collapsed state, heavily
15 assisted by two officers under each shoulder with a very
16 short walking distance, a few steps, to a caged holding
17 cell outside in the yard at the entrance to the custody
18 suite at about 8.03 pm.
19 "It can be seen on CCTV footage from inside Brixton
20 Police Station that on entering the cage Sean
21 immediately collapsed to the ground. Officers claim
22 that he wanted to sleep, which means that his eyes were
23 shut and that he never spoke once throughout. One
24 officer said he thought Sean was mute. Sean is sat up
25 with his back propped against the wall of the cage

1 clearly collapsed, including his legs and his head with
2 officers propping his legs up with their feet, claiming
3 that he was in the way of people coming through the cage
4 to enter the custody suite. He collapsed over again
5 onto the his right side at 8.06 pm and is put into the
6 prone position still cuffed. There were multiple
7 officers inside the cramped cage throughout, about four
8 or five, including the arresting officers who were
9 periodically in and out of the cage into the custody
10 suite speaking to the sergeant and others. No doctor
11 was called to attend to Sean at this time, although
12 there was a forensic medical examiner, an FME, on duty.
13 The sergeant in charge checks on Sean for the first time
14 who was now being put in the recovery position. The
15 sergeant can be heard saying at various times that Sean
16 was faking fitting an unconsciousness, that custody
17 should be cleared as a violent man was coming in and if
18 he dies in here, we're all in the shit. At about 8.11
19 pm, Sean was stood up and held by two officers which was
20 completely inappropriate. The officers claim that Sean
21 just suddenly stood up by himself. After a minute or
22 so, the officers let go and Sean collapsed again to the
23 floor and was assisted and put into the recovery
24 position. Only one hand of the cuffs was released but
25 they were not totally removed. The FME is only now

1 called and attends at 8.30 pm and says that Sean is
2 having a heart attack, should be covered with a blanket
3 and to call an ambulance. Sean is now partially
4 obscured from the inside cameras and only his legs can
5 be seen. One of the arresting officers, the one that
6 was at Sean's neck whilst being restrained, can be heard
7 telling the sergeant that he had Sean's blood on him and
8 I hope he, meaning Sean, 'ain't got nothing'. He also
9 said, 'Oh, Christ he's faking it'. The truth is that
10 Sean was fatally unwell and died shortly afterwards on
11 the cold ground practically naked, wearing only speedos,
12 his trousers had been cut off, at the feet of multiple
13 police officers who claimed that they had been
14 monitoring him. Sean never ever enters the custody
15 suite and was dead within an hour of being arrested, no
16 later on 8.24 pm, when officers shout for defib as they
17 suddenly realise that Sean was not breathing. Officers
18 commenced CPR at about 8.25, 26 pm. The defibrillator
19 machine can be heard advising 'no shock' since there was
20 no heart rhythm. No emergency 999 call was made until
21 8.33 pm when an inspector in the building telephoned
22 down to custody telling them to call 999 directly.
23 Paramedics arrived at 8.36 pm. Sean was asystole and
24 CPR was continued by the paramedics and taken to King's
25 College Hospital at 9.04 pm. He was pronounced dead at

1 9.24 pm."
2 Q. Thank you.
3 A. Thank you.
4 Q. How tall was Sean?
5 A. Not exceptionally tall. I don't recall exactly, but he
6 was -- I am 5 foot 7, he was about 5 foot 8, 5 foot 9,
7 around the same hindsight I think, not exceptionally
8 tall.
9 Q. Do you know what his weight was?
10 A. No, but he wasn't a large man. He was fit and healthy,
11 well toned. He was health conscious about what he ate,
12 he didn't smoke, he didn't take drugs, he didn't take
13 alcohol, and, you know, he was a musician and so he was
14 concerned about the way that he looked and so he took
15 care of his body, of his health.
16 Q. Ms Rigg, there were a number of investigations into
17 Sean's death and the events that followed his death over
18 a period of years and, again, to give some context to
19 your evidence, what I would like to do is take you
20 through three of those reports and I'm looking to draw
21 out perhaps similarities between Sean's experience and
22 Sheku Bayoh's experience.
23 Let's begin with the IPCC report. It's in your
24 folder, we'll bring it up on the screen, it's reference
25 SBPI 00488. So we see from the first page --

1 A. Yes.

2 Q. -- that this is a report by the IPCC, the Independent

3 Police Complaints Commission:

4 "IPCC independent investigation into the death of

5 Sean Rigg whilst in the custody of Brixton police and

6 complaints made by Mr Wayne Rigg and Ms Angela Wood."

7 A. Wayne Rigg is my brother.

8 Q. He's your brother.

9 A. Yes.

10 Q. Thank you, and Angela Wood?

11 A. She was -- she was at the Fairmount Hostel. She was the

12 lady that was making some of the 999 calls, so she was

13 the manager at the hostel where Sean.

14 Q. I see. So this report was intended to investigate the

15 circumstances of the death and as part of that process,

16 account was to be taken of complaints made by your

17 family and by the hostel where Sean lived?

18 A. Yes.

19 Q. The report is quite lengthy, it is 162 pages, I think.

20 It's not dated, but my understanding is that it was

21 shared with interested parties in February 2010?

22 A. Correct.

23 Q. And although it wasn't published until two years later,

24 August 2012.

25 A. Yes, it was published on 1 August 2012, the day of the

1 jury's narrative verdict at Sean's Inquest, but the
2 family through disclosure had received it back in 2010,
3 but of course it wasn't published and so we were aware
4 of the contents but couldn't speak about it.
5 Q. Thank you. So in a little while we will look at the
6 narrative verdict given by the Inquest jury, but in
7 order to get a chronology in our minds, we should
8 understand that the first investigation was the IPCC one
9 and the report was certainly finalised by February of
10 2010, albeit it wasn't published until the day that the
11 Inquest verdict was handed down?
12 A. Yes. Could I just say that when my family and I read
13 the report, we were outraged and we could have decided
14 to judicial review the IPCC at that point, but we
15 decided that we had waited four years to come this far,
16 we didn't want any more delays, and that we knew that it
17 was in response to the family's mind that the content
18 and its conclusions were the wrong ones so we decided to
19 go ahead with it and show them up at the Inquest, which
20 is what happened.
21 Q. Okay. Let's take this in stages. Let's begin by
22 looking at the content and the findings of this report
23 and then we will turn to look at what happened at the
24 Inquest.
25 Let's perhaps begin at page 7, which sets out the

1 terms of reference. So the terms of reference were to
2 investigate the circumstances surrounding the police
3 contact with Sean Rigg on 21 August 2008 as follows:
4 "The circumstances leading to a support worker
5 telephoning the police...
6 "... subsequent to calls to the police...
7 "The arrest of Sean Rigg and his transportation to
8 Brixton Police Station and then to the custody suite.
9 "His time in the custody holding cage up to him
10 being taken to hospital by ambulance at 9.02 pm.
11 "The cause of his death and whether or not any acts
12 or omissions of any police officer caused or contributed
13 to his death.
14 "To establish whether there were any systemic issues
15 within the Metropolitan Police Service which caused or
16 contributed to his death.
17 "To establish whether any acts or omissions of any
18 police officer were motivated by the ethnicity of
19 Sean Rigg.
20 "Post-incident management.
21 "The operation of CCTV systems..."
22 So those were the terms of reference.
23 What I would like to do now is take you to key
24 passages within the report that focus on themes that are
25 perhaps of particular relevance to this Inquiry and they

1 are mental health, the use of restraint, monitoring and
2 evidence of criminality and racial motive. So I wonder
3 if we can turn to page 104?
4 A. Could I just say I have not looked at this report if
5 many, many years.
6 Q. Don't worry. I will take you to the passages that I
7 wish to draw attention to and they'll come up on the
8 screen --
9 A. Thank you.
10 Q. -- too. So we see the heading in the report here:
11 "Officers did not recognise Mr Rigg as a person with
12 mental health needs."
13 And that was one of the concerns that had been
14 brought to the door of the IPCC and which they were
15 tasked with investigating.
16 Paragraph 421 states that:
17 "The above statement according to officers is true.
18 Therefore, the question needs to be asked, should they
19 have recognised him as a person with mental health
20 needs?"
21 And if we can jump down to paragraph 425:
22 "Even if the officers had been aware of Mr Rigg's
23 medical history, the arrest and restraint would not have
24 been handled any differently. Mr Rigg was a man acting
25 in an aggressive and violent manner that attempted to

1 evade arrest, he had assaulted a police officer and was
2 restrained accordingly."
3 So that was the view taken by the IPCC and if we
4 carry on to the next page, please, and look at paragraph
5 427, here a concern is expressed that none of the four
6 officers involved considered the possibility that there
7 might have been an underlying cause for Sean's behavior.
8 And at paragraph 429 there's a summary of that
9 behaviour. It states:
10 "The officers were aware that Mr Rigg was walking
11 the streets semi-clothed, attacking people and
12 performing martial arts moves. He evaded arrest,
13 assaulted a police officer and resisted arrest. The
14 officers witnessed his behaviour in the back of the van.
15 Mr Rigg had been occasionally growling and did not speak
16 to anyone during the course of the whole incident."
17 And carry on:
18 "Despite all of the above indicators, none of the
19 officers considered the possibility that Mr Rigg may
20 have been suffering from a mental illness. If this
21 possibility had been identified, then according to the
22 standing operating procedure where an individual with a
23 mental illness resists the restraints in a violent
24 prolonged manner, the physical stress on the person's
25 body may result in death. Therefore, in all such cases,

1 the police officers concerned must treat the situation
2 as a medical emergency and obtain emergency medical
3 care. The officers insist that they did not realise
4 that Mr Rigg was suffering from mental illness and there
5 is no evidence to suggest that their assertion is not
6 true."
7 And if we carry on, we will see that that is the
8 concluding paragraph under that particular heading
9 within the report.
10 So those were the findings, such as they were, of
11 the IPCC in relation to the officers' awareness or
12 otherwise of Sean's mental ill health. I don't at this
13 stage need to invite your comment on that. I am simply
14 keen to identify passages of this report which perhaps
15 we will see stand in marked contrast to the findings of
16 the inquest jury. So this is really to set the scene
17 and we see from passages that we have looked at what the
18 IPCC had to say about mental ill health.
19 Let's look at restraint now, please. Can we go to
20 page 113, and you'll appreciate this is a very lengthy
21 report and so I am reading it short. So this was a
22 section of the report that looked at restraint and was
23 considering the proposition that Mr Rigg was not
24 restrained in accordance with local and national
25 procedures on restraint of persons with mental illness,

1 so that was the banner. The conclusion at paragraph 462
2 is this:
3 "The statement of Inspector Sutcliffe provides a
4 comprehensive account of the training, thought processes
5 and techniques used when attempting to secure a violent
6 individual. This investigation has uncovered no
7 evidence to suggest that the techniques used by the
8 officers and the level of force applied during the
9 arrest of Mr Rigg was disproportionate or unlawful."
10 So that was their conclusion. And I think I'm right
11 in saying that the IPCC hadn't instructed an expert in
12 use of force. Does that accord with your understanding?
13 A. So the first investigation, whether they instructed
14 somebody -- I don't recall.
15 Q. That's all right.
16 A. I don't recall what they -- what they did. All those
17 original investigators were ex-police officers. I
18 recall that they sent such as a CCTV for, you know, the
19 CCTV to look at the CCTV and to make the compilation for
20 the Inquest was an ex-police officer, which we were
21 concerned about and all those investigators retired very
22 early on into the investigation -- well before the
23 Inquest. So after the first report, this report, they
24 retired, most of them.
25 Q. Thank you. Moving on from restraint, let's look at the

1 monitoring of Sean's health after the restraint had
2 commenced and if we can turn to page 113, please.
3 I think we have just gone beyond 113, sorry, 114, I beg
4 your pardon. It's my fault.
5 So the proposition that was being considered here is
6 that:
7 "The officers failed to monitor Mr Rigg's medical
8 condition and ensure that he received medical attention
9 when it became apparent that was ill. Once the officers
10 realised that Mr Rigg was in need of medical attention,
11 they immediately called for the FME to assess him. This
12 happened when they saw that Mr Rigg had urinated, an
13 obvious sign of some form of distress. Once the FME had
14 assessed Mr Rigg, the officers monitored his condition
15 by watching his breathing. When his condition
16 deteriorated, they again called for FME's assistance.
17 It can be seen from the CCTV footage that the officers
18 were in continual close attendance and their efforts at
19 CPR can be clearly observed."
20 So we don't hear, see any criticism or any
21 suggestion of failings on the part of the officers in
22 terms of their response to your brother's deteriorating
23 condition?
24 A. According to this report, yes.
25 Q. According to report, yes. I am just at the moment

1 looking at what we see on the page.
2 A. Yes.
3 Q. But, yes, according to this report, there don't appear
4 to have been any failings identified in terms of how
5 Sean was monitored after the restraint commenced and
6 after his condition began to deteriorate.
7 A. Yes.
8 Q. Can we move on to page 117, please, and paragraph 499
9 and the proposition that's being considered is a little
10 bit further up, but it's to the effect the family
11 believe the police officers are suspects in the murder
12 or manslaughter of Mr Rigg. So that was a concern --
13 A. Sorry. Where are you reading from there?
14 Q. Sorry. I was actually just for convenience reading, but
15 let's do this properly. Let's go to page 115, please,
16 the very bottom. If we stop there, the way the report
17 is structured is the IPCC have underlined propositions,
18 as it were, based I think on concerns raised by the
19 family and the lady from the hostel. They then go on to
20 consider each one. So the heading is here at the bottom
21 of page 115, but the conclusion we will find at
22 paragraph 499, which is on page 117.
23 A. Yes.
24 Q. So that was the proposition that was under consideration
25 and the conclusion reached was that:

1 "The investigation has uncovered no evidence to
2 substantiate the family's allegation that the officers
3 should be suspects in the manslaughter or murder of
4 Mr Rigg."
5 So we see that was the conclusion reached by the
6 IPCC.
7 Let's look at the findings. We looked at the terms
8 of reference at the beginning and they covered a full
9 page of the report. There were, however, only two
10 findings and if we look at the very bottom of page 141,
11 finding 1, and that relates to the CCTV system which was
12 not in full working order.
13 A. Yes.
14 Q. We can keep scrolling down, please. And finding 2:
15 "The officers adhered to policy and good practice by
16 monitoring Mr Rigg in the back of the van whilst being
17 transported to Brixton Police Station following his
18 arrest."
19 So a positive finding is made that the officers
20 adhered to policy and good practice by monitoring Sean
21 in the van en route to the police station. And those
22 were the only two findings that the IPCC made and you
23 may recall, we looked at the very beginning at the terms
24 of reference and the bulletpoints beneath the terms of
25 reference, one of which was to establish whether any

1 acts or omissions of any police officer were motivated
2 by the ethnicity of Sean Rigg and no finding has been
3 made in the regard at all. The issue appears not to
4 have been addressed at all by the IPCC.
5 A. That's correct, quite extraordinary really.
6 Q. Sorry. I didn't catch that.
7 A. That's quite extraordinary really, because it was part
8 of the terms of reference, yet they did not address it,
9 as you say. It's quite extraordinary.
10 Q. And you say yourself in your statement, and we don't
11 need it on the screen, but for reference it's at
12 paragraph 8, that you believe that Sean's race
13 contributed to the way that he was treated by the
14 arresting officers, but I understand that you didn't
15 raise your concerns with the IPCC and that you were
16 concerned that there might be consequences if you were
17 to do so. Can you say a little bit more about that?
18 A. Absolutely, yes. There was no doubt in my mind or the
19 family's mind that because Sean was black and a man that
20 that didn't cause concern and the way that he would have
21 been treated by police officers. So I categorically
22 repeat now here today that his race must have caused --
23 his race must have been in the minds of the officers at
24 the time of his arrest, but as a family, a black family,
25 we didn't want to be labelled with the term "chip on our

1 shoulder" or that we were pulling the "race card",
2 because that's always the first thing that they say:
3 "oh, you always say we're just being racist."
4 So we decided not to use at the "race card", because
5 Sean is a human, you know, and race shouldn't have to be
6 something that somebody has to look at, because
7 everybody is as a human being and he should have been
8 treated fairly, morally and with care, and that didn't
9 happen. So we deliberately decided not to use the
10 so-called "race card", because we just thought that that
11 was obvious. We didn't want to jeopardise the
12 investigation, we didn't want to appear hostile, you
13 know, we had a campaign, a media campaign, we never used
14 the word "race" or "racism". That was a deliberate
15 decision by the family.
16 Q. Thank you.
17 A. Which was unfortunate. But that's just the way it is.
18 Q. Why do you say it was unfortunate?
19 A. It was unfortunate because in hindsight, you know, they
20 didn't look at the issue of race at all when we expected
21 them to do that naturally. If somebody is -- for
22 instance, for an example, if somebody is being looked
23 for by the police on the street, one of the first things
24 they describe them, IC3 or IC1, male, black male,
25 wearing whatever, you know, to identify who that person

1 is. So why didn't they use any of that in the -- it
2 came up nowhere in the evidence whatsoever by the police
3 officers about this man who was in their custody who
4 they did not recognise had mental health issues although
5 he was black. Really? It's quite strange, but it was
6 unfortunate or deliberate that the IPCC did not address
7 the issue of race. I think that was deliberate.
8 Q. Let's move on from the IPCC and talk now about
9 the inquest. The verdict is a narrative verdict and we
10 have a copy here within the Inquiry papers and the
11 reference is SBPI 00524 and we see here that the inquest
12 was opened on 28 August but adjourned until June of
13 2011.
14 A. Yes.
15 Q. And I think the verdict in fact was given in the August;
16 is that right?
17 A. Yes, the verdict was on 1 August 2012. I should say
18 though between 28 August 2008, a week after Sean's
19 death, that's when it was just, you know, the opening of
20 the inquest to say his name, the date of his death, and
21 where he lived. His death was not ascertained at the
22 time, we didn't know how he died, but between that date
23 and the end of the -- end of the inquest, four years
24 later, there was numerous pre-inquest reviews and
25 discussions regarding disclosure and how the inquest

1 would take form during that time. So it just wasn't
2 28 August 2008 and then the next time was 11 June 2012.
3 There were numerous what we call pre-inquest hearings in
4 between.
5 Q. So there was work going on in the background?
6 A. Yes.
7 Q. But the inquest having been opened on 28 August 2008, it
8 was officially adjourned and resumed on 11 June 2012?
9 A. Yes.
10 Q. The jury gave their verdict on 1 August of 2012, which
11 was roughly six weeks later. Should we understand then
12 that there were maybe six weeks or thereabouts of
13 evidence?
14 A. Yes, I think it was set down for eight weeks of evidence
15 and in the end it was about seven weeks. Some of the --
16 unfortunately, some of the witnesses that were supposed
17 to give evidence towards the end, you know, we were kind
18 of -- the coroner was kind of running out of time and so
19 some of them did not end up giving evidence, but all in
20 all I think it was about seven weeks.
21 Q. Okay.
22 A. Roughly.
23 Q. And we see recorded Sean's full name and then the cause
24 of death, which has been given by the jury as 1(a)
25 cardiac arrest, 1(b) acute arrhythmia, 1(c) ischemia,

1 and 1(d) partial positional asphyxia?
2 A. Yes.
3 Q. We see further down the page that the jury appear to
4 have made a correction to the place death and they have
5 confirmed that the place of death was not King's College
6 Hospital but was Brixton Police Station?
7 A. Yes. Could I just say about that? We found that very
8 important, because we knew from the very beginning that
9 Sean died at Brixton Police Station and the -- and the
10 IPCC or the evidence that was being put forward was that
11 he died at the hospital and so even the jury could see
12 that he died at the police station. So we were very
13 happy that they had actually crossed that out -- they
14 hand wrote it themselves, "Brixton Police Station".
15 That was very important for myself and the family.
16 Q. That mattered to you and we will come back to this when
17 we complete going through the reports and turn to your
18 own personal lived experience. But one of the issues
19 I would like to talk to you about is the information
20 that was put into the media and I understand that the
21 information that was put out there initially was that
22 Sean had died in the hospital and not in the police
23 station.
24 A. Yes.
25 Q. And so as a family, it was very important to you that

1 the jury made that correction?
2 A. Yes.
3 Q. The jury then delivered a narrative verdict. It's more
4 than two pages long. I wonder if we can scroll down to
5 the narrative verdict and, again, I'm going to pick out
6 the aspects that are perhaps most relevant for our
7 purposes. If we could go to the top of that page,
8 please:
9 "On 21 August 2008, 2024 hours, Sean Nicholas Rigg
10 died at Brixton Police Station as a result of a cardiac
11 arrest."
12 There is then some discussion that perhaps we don't
13 need to look at in detail about his medication regime,
14 about relapse in his mental health, about the care
15 provided at the hostel and plans that were in place
16 among stakeholders and so on. But if we can go to the
17 very bottom of the page deals with police response:
18 "The level of force used on Sean Rigg, whilst he was
19 restrained in the prone position at the Weir Estate was
20 unsuitable. In addition, there was an absence of
21 leadership. This led to a failure to take appropriate
22 control of the situation.
23 "It is questionable whether the relevant police
24 guidelines or training regarding restraint and
25 positional asphyxia were sufficient or were followed

1 correctly.
2 "The restraint of Sean Rigg lasted approximately
3 eight minutes whilst the handcuffing took approximately
4 30 seconds. Sean Rigg was in the prone position
5 throughout the entire restraint. The agreed view of the
6 jury is that Sean Rigg was struggling, but not
7 violently. The length of restraint in the prone
8 position was therefore unnecessary. It is the majority
9 view of the jury that this more than minimally
10 contributed to Sean's death. The majority view of the
11 jury is that at some point of the restraint unnecessary
12 body weight was placed on Sean Rigg."
13 And I'm going to pause there just to observe that
14 two of the words that you used in your statement that
15 you read out earlier that you put in inverted commas,
16 "unnecessary" and I think "unreasonable", these were
17 words I think that have come from the narrative verdict
18 of the jury; is that right?
19 A. That's correct.
20 Q. So when you were describing the restraint using that
21 language, that was not your personal assessment, it was
22 based on the verdict of the inquest jury?
23 A. Yes.
24 Q. Let's continue:
25 "Up to the point of being apprehended by the police,

1 the condition and behaviour of Sean Rigg was that he was
2 physical well but mentally unwell. The majority view of
3 the jury is that both Sean's physical and mental health
4 deteriorated during the period of restraint. The
5 majority view of the jury is that during the walk to the
6 van Sean Rigg was physically unwell due to oxygen
7 depravation which occurred during his restraint in the
8 prone position. Sean Rigg was in a V-shape portion in
9 the footwell of the cage in the police van. The
10 majority view of the jury is that he was in this
11 position during the whole time that he was in the cage
12 of the police van (19:50 to 20:03 hours). Sean Rigg's
13 physical health continued to deadline during the journey
14 in the cage of the police van back to the police
15 station. Sean Rigg's mental health was already and
16 continued to be very poor. As Sean Rigg was brought
17 into the cage at Brixton Police Station, he was
18 extremely unwell and was not fully conscious. Sean Rigg
19 was fully unconscious by 20:11.
20 "It is reasonable to expect the police to recognise
21 that there was cause for concern regarding Sean's mental
22 and physical health. It was reasonable to expect the
23 police to have undertaken an assessment of both Sean's
24 physical and mental condition from the point of arrest.
25 No assessment was done of Sean Rigg's condition at any

1 time before he became unconscious. There was an absence
2 of actions by the police and this was inadequate.
3 "The police failed to identify that Sean Rigg was a
4 vulnerable person at the point of arrest and he was
5 therefore taken back to the police station instead of an
6 A&E department despite information about him being
7 readily available and accessible. The police failed to
8 follow the Mental Health Project Team Standard Operating
9 Procedure.
10 "From 19:53 to 20:03 while Sean was inside the cage
11 of the van, there was a lack of care by the police.
12 Whilst in the cage of the police station from 20:03 to
13 20:13 there was an absence of appropriate care and
14 urgency of response by the police, which more than
15 minimally contributed to Sean Rigg's death. Both the
16 action and decision of the police to stand Sean Rigg up
17 was unacceptable and inappropriate. Leaving Sean Rigg
18 in handcuffs was unnecessary and inappropriate.
19 "The views expressed by the police officers that
20 Sean was violent and possibly not unwell deprived Sean
21 of the appropriate care needed and there was a failing
22 to secure an ambulance as quickly as possible.
23 "Whilst Sean Rigg was in custody, the police failed
24 to uphold his basic rights and omitted to deliver the
25 appropriate care.

1 "Despite the efforts of the police to resuscitate
2 Sean Rigg using CPR, and later the efforts of the London
3 Ambulance Service and King's College Hospital, Sean Rigg
4 had already died at 20:24 at Brixton Police Station."
5 A. Yes, a complete hour before it was said that he died at
6 the hospital, a whole hour.
7 Q. The findings of the Inquest jury perhaps stand in marked
8 contrast to the findings, such as they were, of the
9 IPCC?
10 A. Yes, it was stark.
11 Q. And I understand that in fact the day that the coroner's
12 inquest gave its verdict Dame Anne Owers, who was then
13 Chair of the IPCC, announced that she would commission
14 an external review of the investigation to identify
15 areas for improvement for the IPCC and that became the
16 Casale Review of the IPCC investigation.
17 A. Yes.
18 Q. I would like to turn to look at that now. Again, it's
19 in your folder, Ms Rigg, but we'll bring it up on the
20 screen. It's COPFS 02526A and I understand that this
21 was published in May of 2013?
22 A. Yes.
23 Q. And if we can look at what is page 1 of the report, but
24 I think is page 8 on the PDF, here we have a summary of
25 the review's terms of reference which were:

1 "To examine the IPCC investigation in light of both
2 the evidence given at the coroner's inquest and the
3 verdict of the inquest.
4 "To consider whether any further investigation is
5 required with a view to misconduct or criminal
6 proceedings against any member of the police service.
7 "To identify any lessons to be learned or broader
8 issues for both the IPCC and the overall system for
9 investigating deaths following police contact.
10 "To take account of the Rigg family's concerns.
11 "To take account of parallel reviews relating to
12 policing mental health and deaths in custody."
13 So as I understand it this review was to look at the
14 way the IPCC went about their task and to consider
15 whether any further investigation was required and where
16 the review identified the need for further
17 investigation, they didn't carry out that investigation
18 themselves, they didn't look at the evidence that they
19 knew, they effectively remitted matters back to the
20 IPCC; is that correct?
21 A. Yes, that's correct. But could I also add that this was
22 quite unique. This was the first of its kind where the
23 Independent Police Complaints Commission had actually
24 commissioned a review into itself so this was -- set a
25 precedent.

1 Q. Okay. Let's look at the findings of the review. Again,
2 it's a lengthy report, 110 pages or thereby, so we won't
3 go through it page by page, but, again, I would like to
4 perhaps highlight themes that might be of assistance to
5 the Chair. So the review identified a number of
6 failings in the IPCC's approach and a number of areas
7 that they were required to then go back and revisit and
8 look at again.
9 The first of those was the failure to address race
10 and I wonder if we can bring up what is page 20, so I
11 think it's 27 of the PDF. That's perfect, thank you.
12 As you said in your evidence, Ms Rigg, the family,
13 notwithstanding their reluctance to mention race in
14 their dealings with the IPCC, had anticipated it would
15 be considered and indeed it was there in the terms of
16 reference or ethnicity was there in the terms of
17 reference, but there was no consideration at all of race
18 in the IPCC report.
19 A. Yes. Could I just add whether it was in terms of
20 reference, I don't recall exactly, but that would have
21 been part of the family's and our legal team's input
22 that race should be within the terms of reference.
23 I don't think they voluntarily put it there.
24 Q. I see, so was there some sort of consultation process
25 before the terms of reference were finalised?

1 A. I think so.

2 Q. Okay.

3 A. I think so in the early days, yes.

4 Q. And the family and their legal team would have had an

5 input to that process?

6 A. Absolutely.

7 Q. Right. You can identify that the heading there "Mental

8 health issues", two paragraphs above that:

9 "The review considers that the IPCC should have

10 addressed the issue of race, as included in the terms of

11 the reference of the investigation. The lack of

12 reference to race throughout the report is not a sign of

13 nondiscrimination, but rather an indication of malaise

14 and/or lack of confidence about how to address racial

15 issues appropriately."

16 So that was Dr Casale's view in relation to the

17 IPCC's failure to consider race. Moving on,

18 I understand that the review also considered that the

19 failure to call into question the arresting officers'

20 position that they were unaware that Sean was suffering

21 from a mental health crisis, given the clear indicators

22 set out in the report, which the review considered were

23 manifest and arguably not difficult to recognise, so

24 there was a criticism?

25 A. It was blatantly -- it was blatantly obvious that Sean

1 was suffering with mental health on that particular day
2 and also he was known to the police for previously of
3 suffering with mental health. He was in the police
4 record. He was known to the police and it was obviously
5 by his bizarre behaviour that it was not ordinary
6 behaviour by ordinary member of the public who was not
7 suffering with mental health.
8 Q. You say that Sean was known to the police and they knew
9 of his mental ill health, was it your understanding then
10 that information would have been recorded on the police
11 system --
12 A. Yes, it was.
13 Q. -- that he was mentally unwell?
14 A. Yes.
15 Q. If a systems check had been carried out, that
16 information would have come to the attention of the
17 police?
18 A. Yes.
19 Q. Is that right? And am I right to understand that at the
20 time of his arrest and restraint Sean was carrying his
21 passport?
22 A. Correct.
23 Q. Which would have had his name and date of birth in it?
24 A. Yes. Not only that, on the day there were a series of
25 999 calls being made by the hostel staff to take Sean to

1 a place of safety where his name was given, that he was
2 relapsing, he was being psychotic, and hallucinating and
3 that they tried to find a bed at the mental health care
4 team, the South London and Maudsley. There were no beds
5 available, so the next step is for the police to arrest
6 him under Section 136 and take him to a place of safety,
7 which is a hospital. All of that information was given
8 and it was recorded in the first CAD record, the first
9 999 call, which was at 4 something to 5 pm. I can't
10 remember the exact time, 4 something to 5 that day.
11 Q. So as well as the indicators of mental ill health that
12 might have been apparent from Sean's behaviour, he was
13 known to the police, on police systems, carrying a
14 passport, and the hostel had alerted the police using
15 the 999 system to his deteriorating mental health and
16 the need for him to be taken to a place of safety?
17 A. Correct. There were also 999 calls made to the police
18 by members of the public who could also see that he was
19 suffering with mental health. During the inquest, the
20 original 999 call was made and clearly that witness
21 said, you know, that he suffered with mental health. It
22 was obvious, blatantly obvious, to everybody, except the
23 police.
24 Q. And certainly the Casale Report concluded that there
25 were -- and I'm quoting here:

1 "... manifest and arguably not difficult to
2 recognise indicators of the deterioration in Sean's
3 mental health, all of which were in fact set out in the
4 IPCC report, and they include the fact that he was out
5 in public in a state of undress, he was naked from the
6 waist up; he was performing martial arts moves and
7 throughout the entire time that he was in contact with
8 the police, he didn't speak a word."
9 A. That's what the police say. We don't know what he said
10 or what he didn't say, because we were not there, but he
11 was obviously unwell. He was in and out of traffic, you
12 know, he was in the middle of the street doing karate
13 moves which was -- so he was a danger to himself and he
14 was a danger to the public. He was kicking out doing
15 karate moves because he was -- he was exercising, doing
16 Wing Chun. That's what he did, that's how he kept his
17 body fit, but he didn't actually make contact. He
18 didn't hurt anybody. He was kicking out and then
19 turning around and doing it again, so he was just doing
20 martial arts movements in the street.
21 Q. Let's look briefly at page 19 of the report. That will
22 be page 26 of the PDF. At the very bottom of that page,
23 please:
24 "The review considers that there were a number of
25 concerns that could and should have been raised in the

1 IPCC report and the first of those is that the position
2 adopted by officers that they were not aware that
3 Mr Rigg might be suffering from mental health problems
4 was open to question on the grounds of improbability,
5 given the clear indications of mental illness enumerated
6 in the report."
7 So here the review was critical effectively of the
8 IPCC's failure to question the officers' position that
9 they simply didn't realise that Sean was in crisis,
10 given the clear indicators that were set out in the
11 report itself?
12 A. Well, had they checked the passport, because he was
13 arrested for theft of his own passport where the
14 officers claimed it didn't look like Sean. It was Sean,
15 it looked identical. I recall the passport being shown
16 to the jury together with the autopsy photographs to
17 prove that it did look like him.
18 I was going to add something else, but I have lost
19 my trail of thought. Could you repeat the question or
20 was there a question? I don't think.
21 Q. I don't have the live transcript in front of me. There
22 we are.
23 A. I don't think you asked me a question. You were
24 commenting. There was something else I was going to
25 say. I can't recall.

1 Q. Well, I had taken you to the part of the report where
2 the review were critical of the IPCC's failure.
3 A. Oh, yes.
4 Q. Has it come back?
5 A. I remember. But they didn't check the name of the
6 passport. If they had checked and radioed in, they
7 would have brought up that this man suffered with mental
8 health and had a history as well so ...
9 Q. We've looked at what Dr Casale had to say about the
10 failure to address race, about the failure to question
11 the officers' position that they didn't realise that
12 Sean was experiencing poor mental health. Let's look at
13 the other criticisms that came out of the report. There
14 was also a criticism of a failure on the part of the
15 IPCC to examine in detail the restraint methods used and
16 to robustly analyse the officers' justification for
17 their use of restraint.
18 And I wonder if we can perhaps look at page 85, so
19 92 of the PDF. It's the second bottom paragraph. It
20 begins "the IPCC". There we are:
21 "The IPCC investigation report considered the use of
22 force, including the restraint of Mr Rigg, to have been
23 necessary and proportionate and thus, that there was no
24 basis for considering that the police officers
25 contributed to his death. However, in light of the

1 evidence that emerged at the inquest, the review
2 considers that the duration of the restraint in the
3 prone position appears to have been prolonged beyond the
4 threshold of what could be regarded as necessary,
5 proportionate and reasonable. In turn, this may have an
6 impact on the question of the police officers'
7 contribution to the death of Mr Rigg."
8 So another criticism here for a lack of robustness
9 in the analysis around the use of force. And if we
10 might look briefly at the bottom of page 23. Sorry,
11 that will be PDF page 30.
12 A. Yes.
13 Q. Thank you. Thank you, sorry. The paragraph above the
14 heading "resources":
15 "The review emphasises how important it is for the
16 IPCC to be independent and to be seen to be independent.
17 The perception of independence is an important factor in
18 public confidence. For the future, this should be borne
19 in mind when choosing external experts. The review
20 recommends that the IPCC ensure that competent expertise
21 is available to IPCC investigations from a wider range
22 of independent experts, including restraint experts."
23 And we touched on this earlier, Ms Rigg. I asked
24 whether you knew whether or not the IPCC had instructed
25 an expert on use of force and you were unsure, but it

1 would appear I think, from this comment by Dr Casale's
2 review, that there hadn't been an expert on restraint
3 brought in to assist the IPCC and there's comment
4 elsewhere in Dr Casale's report that the IPCC didn't
5 have an expert on mental health to assist them either
6 so -- so more --
7 A. I find that extraordinary that you've -- I probably knew
8 that at the time, but, you know, it's almost 16 years
9 and of course, you know, that's extraordinary that they
10 didn't look at what was blatantly obvious, mental health
11 and, yes.
12 Q. That they perhaps didn't look at what was blatantly
13 obvious, but also didn't have the benefit of an expert
14 opinion commenting on Sean's state of health at the
15 time.
16 Let's move on and look at another matter that
17 concerned the review team. If we can look at page 14,
18 which is page 21 of the PDF, please. And this concerned
19 the officers having the opportunity to -- potentially
20 having the opportunity to talk to one another, the
21 officers not being separate.
22 A. Yes.
23 Q. If we could scroll down please, perfect. It's the
24 paragraph beginning "Of serious concern":
25 "Of serious concern is the fact the four police

1 officers were not kept separate during the night of
2 21/22 August. The IPCC investigation report makes no
3 reference to this and it only emerged at the coroner's
4 inquest that the four officers were initially separate,
5 but were then placed together for more than an hour with
6 a member of the MPS before a joint meeting in the early
7 hours of 22 August involving various parties. The
8 review does not understand the reasons given for this,
9 including that the IPCC team were only observers at the
10 joint meeting, because the decision as to the mode of
11 investigation was not made until later that morning.
12 "The review considers that in the interests of an
13 effective investigation the arresting police officers
14 should have been separated and instructed not to speak
15 or otherwise communicate with each other about the
16 events until the IPCC was able to take detailed initial
17 statements from each. This should be standard practice
18 in cases of deaths in police custody. Such a safeguard
19 would not preclude any necessary support being provided
20 to each officer individually by appropriate other
21 people."
22 A. Yes.
23 Q. Were you as a family aware that the officers had been
24 placed together in a room for a period of time?
25 A. Yes.

1 Q. When did you become aware?
2 A. Perhaps during the investigations by the IPCC. So we
3 had a liaison officer that would update us periodically,
4 monthly, so it might have come up in conversation where
5 we were updated and so I also think we were privy to
6 disclosure of documents. Once the IPCC's report was
7 finished in 2010, that's when we started to get the
8 documents. I recall at one of the pre-inquest reviews
9 we were able to gain access to the independent police --
10 into the IPCC's offices to look at the documents that
11 they were holding and we used the precedent of the case
12 of the Ian Tomlinson case where that first happened
13 where we could actually go into the offices and see what
14 paperwork they had.
15 So when my solicitors did do that they had the --
16 the IPCC had a file called "unused material". All of
17 that material was taken out and some of the best
18 evidence was there and I think some of the initial Gold
19 meeting notes were there. And I can't remember when I
20 first became aware of when they were all put in the
21 room, but I knew well before the inquest that that had
22 happened. And I think what was said when we were
23 arguing as a family as to why that happened, they said
24 that somebody was in the room to make sure that they
25 didn't speak, but they couldn't remember who that person

1 was and, you know, we never got to the bottom of that.
2 But, ironically, during the inquest one of the officers
3 had said, well, during cross-examination that they had
4 meetings on the night, gold meetings, and the IPCC were
5 there and notes were being made, which we were unaware
6 of. So what happened is that that particular
7 investigator had to come and give evidence and produce
8 those -- those notes that were made at the time on the
9 night.
10 So that was information that had been hidden from
11 us, but I think on those notes, if I remember correctly,
12 it would be, you know, there were transcripts of the
13 inquest as well, so I think what happened was that they
14 had recorded that there were injuries -- I can't
15 remember everything that was in that note, but the IPCC
16 were there on the night of Sean's death and, yes. So
17 much things happened it's just -- we were just really
18 surprised that they were allowed to sit in the same room
19 while somebody was making sure that they didn't speak,
20 but yet they can't -- they don't know who it was that
21 was in the room with them.
22 Q. Okay. Let's move on to another criticism that comes out
23 of the Casale Review and it relates to police interviews
24 or interviews of the police officers. I wonder if we
25 can look at page 95, which is 102 of the PDF, and it's

1 just underneath the heading "IPCC interviewer stance
2 towards the police officers":
3 "The interviewers did not pursue failures on the
4 part of the police with sufficient rigour (e.g. the
5 police officers' failure to establish that the passport
6 was Mr Rigg's and their failure to recognise indicators
7 of mental illness). Most of the interviewers appeared
8 ready to accept the police officers' view of events
9 without following up potential lines of questioning.
10 Some of the IPCC interviewers appeared to have the same
11 expectations about police performance as the police
12 officers' own understanding of what might have been
13 expected of them. Those expectation were generally low.
14 In the opinion of the review, they do not always
15 correspond to acceptable standards for police
16 performance."
17 So we see here a criticism of the rigour with which
18 the interview process was carried out when the police
19 witnesses were called to give statements?
20 A. Yes. I think I recall as well during the time when they
21 were interviewed under caution which was, you know,
22 seven, eight months later that they had a Police
23 Federations representative who was actually answering on
24 behalf of the police officer during -- being
25 interviewed, which was completely inappropriate. And I

1 think it was something like, you know, I think it was
2 about the mental health issue and whether that was --
3 whether it was recognisable or if it was normal or
4 something. And I recall the Federation representative
5 had said "What's normal in Brixton?" or something like
6 that.
7 Later on he was actually one of the arresting
8 officers that the IPCC arrested, one of the three
9 officers that were arrested. It was that same
10 Federation officer that was there in the very beginning.
11 I think he was there on the night as the welfare
12 Federation representative and also during the inquest,
13 and at the time when they were being interviewed as
14 well. It was the same officer.
15 Q. Yes.
16 A. Geoffreys, his name was.
17 Q. And I don't have the reference at my fingertips, but I
18 seem to recall that Dr Casale took the view that that
19 intervention by the Police Federation officer was
20 inappropriate?
21 A. Yes.
22 Q. And shouldn't have happened and she was critical of that
23 intervention?
24 A. Yes, I'm not certain, but I wonder if he was the person
25 that was in the room at the time when they were all

1 sitting in their office. I cannot be certain, but I
2 suspect maybe it was him. I don't know.
3 Q. I want to turn now to an issue concerning the
4 thoroughness of the --
5 A. Sorry.
6 Q. An issue concerning the thoroughness of the IPCC
7 investigation, because I understand that the IPCC
8 recorded in their report that the custody sergeant had
9 gone out to check on Sean when he was in the back of the
10 van in the yard at the police station?
11 A. Yes.
12 Q. And reported that he was sitting on a bench. He said he
13 spoke to Sean, had eye contact with him, and satisfied
14 himself that Sean was conscious and there was nothing
15 that he needed to do with regard to his immediate care.
16 So that's a lift from the IPCC report. I'll not put it
17 up on screen so that we're not constantly jumping
18 between documents.
19 But let's look at what Dr Casale had to say about
20 that and we'll find her comments on page 2 of the
21 report, which is page 13 of the PDF. Just a little
22 further down. Thank you, that's perfect. So there was,
23 of course, CCTV at the police station. This is
24 underneath the heading "Custody and care at the police
25 station", two paragraphs down.

1 A. Yes.
2 Q. "The IPCC investigation considered the evidence of the
3 CCTV at Brixton Police Station, but was not able to
4 devote the time to this exercise accorded by members of
5 the Rigg family, who painstakingly viewed and reviewed
6 the evidence over a period of months. The upshot of
7 this intensive scrutiny of the CCTV footage was the
8 discovery by the Rigg family that the custody sergeant
9 did not visit Mr Rigg while he was in the police van
10 parked in the yard at Brixton Police Station."
11 A. Yes, it was my brother Wayne that first uncovered that.
12 Q. "This crucial finding emerged at the coroner's Inquest.
13 The IPCC had accepted Sergeant White [that's the custody
14 sergeant] and PC Harratt's accounts that the sergeant
15 had visited Mr Rigg while he was waiting in the van.
16 The review understands that the differing accounts
17 provided by these police officers to the IPCC and to the
18 coroner's inquest are the subject of a separate
19 investigation."
20 I wanted to ask you some questions about this. Are
21 you concerned that the IPCC didn't devote sufficient
22 time to the analysis of the footage and that they failed
23 to identify that the custody sergeant had not visited
24 Sean as they claimed?
25 A. I'm more than concerned. So at the very early stages of

1 investigation before -- just after Sean died and before
2 the first official meeting with the IPCC, which was in
3 September 2008, the family had quite -- you know, the
4 family had viewed the footage at the offices of the IPCC
5 with our solicitors, Hickman & Rose, and it was
6 Anna Mazzola was our solicitor at the time working with
7 Daniel Machover and we saw the CCTV within the custody
8 suite and this was just weeks after Sean's death so
9 there was no time tampering or anything like that. So
10 we knew that the CCTV showed everything.
11 When years later and we had also -- we had also --
12 they had also disclosed CCTV footage to us after the
13 2010 report so my brother Wayne and myself were going
14 through the CCTV meticulously, there was also audio, but
15 they had been given it to us in a state that was
16 difficult to follow. It was de-synchronised. There was
17 footage embedded in other footage so it was difficult to
18 follow, but that's all we had to work with. Eventually,
19 weeks before the inquest or a month or two before the
20 inquest, we were given a compilation CCTV that was going
21 to be used in the court. So the IPCC had sent it to an
22 expert, which was an ex-police officer. You know we
23 were arguing with the family. The family were concerned
24 about that, what was the independence of sending it to
25 an ex-police officer, but they did that anyway.

1 When we received the footage that was going to be
2 used at the inquest, the compilation CCTV, it was
3 missing or spliced, I like to use, 29 seconds from the
4 footage, the original footage. 29 seconds is quite a
5 long time when you look at it. And the footage that we
6 were given was that the van had arrived into the station
7 and then suddenly Sean was in the caged area in the
8 holding cell collapsed. So 29 seconds was missing, the
9 bit where Sergeant White did not go to the van and the
10 bit where we could not see that Sean was removed from
11 the van and heavily assisted. He did walk, but it was a
12 strange walk. That was all missing, but we knew it
13 existed you see. So we had a pre-inquest review with
14 the coroner insisting that we received the full footage
15 and he agreed and so we -- when that was received, my
16 brother was one of the first ones to look at the footage
17 and that's when we uncovered that Sergeant White never
18 left the custody suite.
19 He went into the caged area but if he had just taken
20 one more step, one step, we would never have known,
21 because there was a wall and you couldn't see. There
22 was cameras inside the yard where the van was parked.
23 That camera went missing or did not exist. We were told
24 it didn't exist when we said it did exist, because we
25 had seen it ourselves two days after Sean had died.

1 It's kind of difficult to go back and forth, but we had
2 physically seen the camera outside in the yard, which
3 would have captured what was happening to Sean in the
4 van once he had arrived. And the IPCC first said that
5 that camera didn't exist and when we said it did, they
6 said, oh, it's not been working for three months and
7 then we asked, well, how often do you maintain the CCTV
8 at Brixton Police Station and we -- when was it last
9 maintained, the last maintenance of it? And there was a
10 report done and they came back and we were told that it
11 had been maintained nine days before Sean had died,
12 where all the CCTV in Brixton Police Station was working
13 and then the IPCC came back and said to us that that
14 must be wrong. That must have been a mistake. So
15 basically they denied the fact that CCTV was working on
16 that night.
17 There was also another camera within the caged area,
18 if I remember rightly, that would have probably given a
19 bird's-eye view of what was happening in the cage with
20 Sean and it's those two cameras that we've never seen.
21 So the footage that can be seen that was shown at the
22 inquest is from a camera that was in the corridor
23 looking into the cage, but we knew that there was
24 footage -- there's also another camera from the gate so
25 when the van arrived, you could see within the yard. So

1 basically what I'm trying to say is we were given a
2 faulty, or what I would call tampered footage, missing
3 29 seconds, which proved that Sergeant White did not go
4 to the van and that was footage given to us by the IPCC.
5 So they must have known.
6 Somebody must have known. How could they miss 29
7 seconds missing, because there's a clock, you know,
8 there's a clock on the footage with audio. There's a
9 clock and we studied it meticulously, my brother and I,
10 and that's where we saw that 29 seconds was cut out.
11 Q. And I understand that the sergeant in question was later
12 prosecuted for perjury, having given evidence on oath at
13 the inquest, although he was acquitted after.
14 A. Eventually. That was difficult to get him on the
15 stand, but we did eventually get him on the stand after
16 a few appeals using the right to review scheme, I think
17 it was called.
18 And three officers had been arrested in fact, as I
19 had mentioned earlier, because of the evidence that was
20 given on oath that Sergeant White claimed that he did go
21 to the van and gave detailed cross-examination to the
22 coroner and to the jury, but that was a complete
23 fantasy. He remembered a complete fantasy, because it
24 did not happen. So when we did get him to the stand, we
25 had the first perjury trial in history for a death in

1 custody. That was another precedent.
2 Q. Another first?
3 A. Yes.
4 Q. We have looked this morning at the IPCC report, and
5 their findings, we've looked at verdict handed down by
6 the inquest jury and we have dipped into the some of the
7 criticisms made by Dr Casale in her review of the way
8 that the IPCC went about its task.
9 Now, I understand that's not in fact the end of the
10 matter, that there have been developments since and
11 I think in fact the more recent developments are
12 summarised in a statement that was issued by the IOPC,
13 as they now are, in September of last year. So I think
14 for expediency we'll perhaps bring that statement up and
15 look at it very briefly. We normally break at around
16 about half past 11, but I think will perhaps have time
17 to have a quick look at it. It's WIT 00018. No, that
18 is not --
19 LORD BRACADALE: Why don't we just take the break now and
20 you can get organised. We'll have a 20-minute break
21 now.
22 (11.29 am)
23 (A short break)
24 (11.56 am)
25 LORD BRACADALE: Ms Thomson.

1 MS THOMSON: Thank you. Before the break I was keen to take
2 you to another document, but I had the wrong reference
3 number and so the wrong thing came up on the screen,
4 I think we have it now. It's WIT 00108.
5 A. Oh, yes, this one.
6 Q. Yes. So this is from the IOPC, which has replaced the
7 IPCC, and it's headed up "The circumstances of the
8 Sean Rigg's death and the history of the IPCC and IOPC
9 involvement." And I thought this might be a useful
10 document to take you to, Ms Rigg, because it sets out a
11 summary of what has happened since the Casale Review?
12 A. Yes.
13 Q. I thought we could look at this, probably in quite short
14 compass, and then I would like to move on to talk to you
15 about your lived experience, but I'm conscious that the
16 story didn't end with the Casale Review and I think it's
17 important to give context to what happened beyond that
18 report.
19 So if we could perhaps scroll through this document.
20 We see here some of the circumstances that we've already
21 heard about and you have given evidence about today, so
22 I think we can probably skip through. There is -- if we
23 pause here, there's reference to the inquest. You were
24 right it was seven weeks, 60 witnesses and the 1 August
25 was the date that the jury handed down their verdict.

1 The following paragraph sets out that in light of
2 the jury's conclusions, the IPCC commissioned an
3 independent review and that was of course
4 Dr Sylvia Casale's review published in May 2013.
5 Then there is a summary of some of the conclusions
6 in the Casale Review and then beyond that, if we can go
7 to the paragraph "following the Casale Review", and
8 let's read from thereon:
9 "Following the Casale Review, the IPCC conducted a
10 second investigation, which concluded in February 2016."
11 And I'll pause there just to note that that is what
12 we discussed earlier that the Casale Review didn't look
13 at matters afresh. It simply looked at way the IPCC had
14 gone about its task and to the extent that it identified
15 failings, those were brought to the attention of the
16 IPCC and the matter was effectively remitted back to the
17 IPCC to look at again.
18 A. Yes, I think Sylvia went through all the evidence with
19 her are team as to what came out in the inquest, but she
20 did speak with -- I know she spoke with us, the family.
21 I don't know who else she spoke to to do that
22 investigation, but she had all of the evidence that had
23 been put before the inquest. I don't know what else she
24 had. I don't recall, but like, yes.
25 Q. So her review was never going to be the final chapter in

1 the story. It was simply a vehicle to identify
2 failings --
3 A. Yes.
4 Q. -- so that they could be brought to the attention of the
5 IPCC who would go back and revisit the work they had
6 done previously?
7 A. That's correct.
8 Q. And here we see a reference to the IPCC's second
9 investigation in February 2016.
10 A. Yes.
11 Q. "The IPCC was of the view that five officers should face
12 gross misconduct allegations. Each officer faced
13 allegations relevant to their involvement. These
14 included the failure to identify and treat Sean as a
15 person with mental ill health, use of excessive
16 restraint and false evidence given to the IPCC and on
17 oath at the inquest."
18 These are all failings that we discussed in your
19 evidence before the break that were drawn out in the
20 Casale Review.
21 A. Yes.
22 Q. If we read on:
23 "In September 2017, the Crown Prosecution Service
24 decided there was insufficient evidence for a successful
25 prosecution against any officer in relation to the

1 events surrounding Sean's death. In November 2016, a
2 custody sergeant was acquitted of perjury charges
3 arising out of his evidence to the inquest."
4 And that was Sergeant White and, again, we spoke
5 about him before the break and about the critical role
6 of the CCTV evidence and what was uncovered by the
7 family, rather than the IPCC.
8 A. Yes.
9 Q. There were lengthy delays between March 2016 and
10 March 2018 when the IOPC directed the MPS, the
11 Metropolitan Police Service, to bring disciplinary
12 proceedings?
13 A. Yes, that was long and drawn out. We were in
14 discussions with the -- with the IPCC and the Met.
15 I remember DAC -- I think her name was -- Fiona Taylor
16 was involved in that and also with -- after the inquest
17 there was a Rule 43 report, a prevention of future
18 deaths, where the coroner had made recommendations as
19 well.
20 So alongside the Casale Review there was other
21 things happening. So there was at the coroner's Rule 43
22 report and the responses by the Metropolitan Police and
23 the Lambeth Council and the mental health team so, yes.
24 Q. There was a lot going on.
25 A. Yes.

1 Q. I have considered the Rule 43 report. I'm not going to
2 bring it up on the screen because the focus was more
3 around what had happened in the hostel and the
4 background events, rather than really the actions of the
5 police, but we see here "Delays" and then in March 2018,
6 the IOPC directed the MPS to bring disciplinary
7 proceedings and Sean of course passed away in 2008, so
8 we're looking at nearly ten years later before there was
9 a direction that disciplinary proceedings should be
10 brought?
11 A. Yes. There was a difficulty as to the delay into which
12 the police would agree to -- the Metropolitan Police
13 would agree to the misconduct hearing, so we were back
14 and forth on that and then, eventually, they were
15 directed by the IPCC to do that, IOPC rather.
16 Q. Almost ten years later. And what was the impact on you
17 and your family of that delay, that passage of time
18 between Sean's death and disciplinary proceedings being
19 instigated?
20 A. Yes, it was unnecessary and painful and upsetting and
21 made you angry, because the delays -- you know, we knew
22 what happened. We had all these -- we had had the
23 inquest findings, we had had the Casale Review findings.
24 You know there was so much evidence to show that, you
25 know, there should be some disciplinary action, if not

1 criminal and it was taking decades. So ten years down
2 the line it was exhausting, but at least we were still
3 there and it didn't finish back in 2012.
4 So the pursuance of -- from the family, you know, to
5 just at every juncture was also tiring, but it meant
6 that, you know, ten years later it hadn't gone away and
7 now there was the opportunity for it to be looked at
8 again. Ten and a half years later the officers claimed
9 that they couldn't remember what happened ten years
10 before. So suddenly in my view they all suffered with
11 memory loss, even though there was footage to remind
12 them of what actually happened on the night. And so
13 they had made an application on the basis that it was
14 the length of the case, ten and a half years later, and
15 that they -- it was a delay and it was traumatic for
16 them and they thought it would be unfair for the gross
17 misconduct hearing to go ahead. And as an interested
18 party, I was able to -- to put my input into that and
19 the family's for the -- on behalf of family and
20 I remember it was my birthday, 1 February 2019, it was
21 going to go ahead, finally, almost 11 years later.
22 Q. Let's return to this document.
23 Some of what you have said I think we'll see echoed
24 in the next paragraph:
25 "Following a six-week hearing, which concluded on

1 1 March 2019, over ten and a half years after Sean's
2 death, a police misconduct panel determined that none of
3 the gross misconduct charges were proven against the
4 five police officers. The hearing reached this
5 conclusion having rejected submissions that the charges
6 should be dismissed due to delay."
7 A. Yes.
8 Q. So the officers who were subject to the disciplinary
9 proceedings had put forward an argument that the
10 proceedings shouldn't be allowed to take place because
11 of the impact of the delay; is that right?
12 A. Yes.
13 Q. Okay. And what impact did that --
14 A. But they were the ones that delayed it in the first
15 instance and the investigators, you know, so it wasn't
16 the family's fault, it was them. They were using, you
17 know, their beating stick that they caused in the first
18 place with the delays and then tried to say that they
19 can't remember and it wouldn't be fair and it was
20 traumatic, but what about the family?
21 Q. Mm-hmm.
22 A. It was infuriating.
23 Q. If you could cast your mind back to that period in time,
24 what was the impact on the family of the fact that the
25 officers were putting forward this argument that the

1 disciplinary proceedings shouldn't go ahead because of
2 the delay and perhaps also due to the trauma for them
3 that you have mentioned? How did the family feel about
4 that? What impact did it have?
5 A. The impact was affected our wellbeing, anxiety and
6 having to relive it, post-traumatic stress. The fact
7 that, you know, we wasn't going to see any
8 accountability. They were trying to escape
9 accountability and then so there was no misconduct
10 hearing, but all that would have happened was that they
11 would have been sacked, you know. Nobody was going to
12 go to prison by this stage, nobody was going to be held
13 accountable, but we felt that there was sufficient
14 evidence for there to be a misconduct hearing, but
15 obviously this was a police tribunal and it was out of
16 the hands of the officers.
17 So what was extraordinary is that we felt like we
18 were being criminalised. So there was security that
19 followed me everywhere I went, including to the lady's
20 toilet right outside the cubicle.
21 Q. Yes, I think you mentioned that in your statement.
22 A. Yes. What did they think I was going to do to them? We
23 were in a police vehicle -- police building and I don't
24 know, did they think I was going to pull a gun out or
25 something? I have no idea but, I found it

1 extraordinary. Yet, the officers were as close you are
2 to me, I could touch their shoulders if I wanted to, and
3 they could just go about their business. They were
4 sitting in the same canteen where we were having lunch.
5 You know, it was extraordinary, but yet we were being
6 treated like the criminals here.
7 It was also a public hearing. I think that was
8 something that we were campaigning for, because
9 misconduct hearings were being held in secret, if I
10 recall, in the past and I found that extraordinary. So
11 we wanted it to be a public hearing, which did happen,
12 but there was nothing public really about it, because
13 the press and the -- the press and the public were made
14 to sit in a completely different building across --
15 around the corner with a screen such as this. And so,
16 you know, the CCTV in its entirety was going to be
17 shown, but it kept breaking down and so the public
18 couldn't actually follow properly the public hearing.
19 I was actually in the room, so they had allowed
20 three chairs for the family to attend, but we were
21 heavily secured with security. Even for me to watch the
22 CCTV within that room it meant that I had had to go --
23 to get up and move so that I could see, you know, head
24 on, because I was sitting like these gentlemen are here.
25 I was sitting aside and I couldn't see the screen, so to

1 go into the middle of the room security followed me and
2 was in my face whilst everybody is watching the CCTV my
3 brother is dying on -- my brother dies on camera and
4 everyone is watching it and yet that police -- that
5 security officer was in my face.
6 I was absolutely furious. It was painful. I was
7 angry and, you know, there was nothing public about it I
8 felt. Yes, it was wrong. And that -- because of that,
9 after the misconduct hearing, I insisted with Inquest
10 and my legal team that I have consultations with the
11 Metropolitan Police, which is what I did, which also
12 included other governmental bodies. I can't remember
13 exactly who they were, but someone from the Mayor's
14 office, the Met, myself, and others. I could get that
15 to you, but to consult with them as to the way that
16 families were treated at any hearing, be it the inquest
17 or if you're lucky to get a prosecution by the state, if
18 you're very lucky to get that, and certainly at a
19 disciplinary hearing, which is fairly rare as well, to
20 get them into a disciplinary hearing and yet the family
21 are the ones that are treated like the criminals.
22 It's totally, totally unacceptable and that's why
23 I was consulting with the Metropolitan Police into the
24 way that they treat families and the way that they
25 conduct public misconduct hearings in the police.

1 Q. Thank you. Returning to those documents. So you've
2 described very clearly the impact on your family, not
3 only of the delay and the submissions that were made on
4 behalf of the officers with a view to halting the
5 proceedings in their tracks, but also your experience of
6 trying to participate in that process effectively.
7 As we see from the text here:
8 "At the conclusion of the evidence, the police
9 misconduct panel dismissed the charges of gross
10 misconduct finding that they hadn't been proven, but
11 subsequently three officers pursued a civil claim
12 against the IOPC arising from the length of the
13 investigation faced by them. The claim was settled on
14 agreed terms earlier this year [that is 2023] but
15 without notifying Sean Rigg's family of the claim or the
16 settlement. It came to their notice via a public
17 statement published by the Police Federation on
18 15 May 2023, the facts of which, in the view of the IOPC
19 and Marcia Rigg, clearly indicated that it related to
20 the investigation into Sean's death, even though neither
21 he, nor the police officers, were named."
22 And it concludes by saying:
23 "It is in this context that on the 15th anniversary
24 of Sean's death, the 21 August 2023, the acting Director
25 General of IOPC, Tom Whiting, wrote to Marcia Rigg in

1 the terms set out in the IOPC's apology."
2 So you ultimately received an apology from the IOPC
3 for their failure to tell you that this claim had been
4 brought and that it had been settled by the IOPC?
5 A. Yes, but I must add that it wasn't willing. I had to
6 engage and see that. So what happened is I saw a
7 Police Federation article on their website. I don't
8 know if they Tweeted it or something. I can't remember.
9 Anyway, officers -- three of the arresting officers
10 received compensation because of the delay, almost
11 11 years, and the trauma that it impacted on their
12 family and their private life, which was infuriating.
13 And the IPCC did not tell the family. So I'm just came
14 across it by chance, you know. I became aware of the
15 article and when I read it, I knew it was about Sean and
16 I immediately made it public on my Twitter page alerting
17 the Federation and the IPCC that I was aware of the
18 secret, because this was a confidential agreement
19 between the police officers and the IOPC which was
20 sanctioned by the Home Office who wrote the cheque and I
21 wondered how many times has this happened before.
22 Q. What impact did this discovery have on you and your
23 family?
24 A. What impact? I can't describe. I was angry. I'm still
25 angry now, as you can see. It's totally unfair and

1 obviously the police officers didn't want us to know
2 about it. I mean one of them became a priest in the
3 Church Of England. You know, these officers had went
4 public in the media. I remember Birks wearing his dog
5 collar and going on ITV News saying he was traumatised,
6 but also saying he would do the same things again. And
7 I suspect he was one of these officers that received the
8 compensation and other officers as well, arresting
9 officers, had been to the newspapers. These are public
10 documents. They claim that they were suffering with
11 their mental health and that they -- one of them had
12 turned to drink.
13 I don't doubt that that may have happened, but that
14 also happened to us as the family. But all our trauma
15 and our grief had just gone unnoticed, just we were
16 nothing. And I am somebody and I'm human as well and so
17 was Sean and that's absolutely outrageous that police
18 officers after what they did can be paid compensation by
19 the IOPC. What's that all about? No, that's not right.
20 No.
21 Q. So far this morning, Ms Rigg, we have looked at what
22 happened on the night of Sean's death and we have taken
23 a tour through the various reports that followed by the
24 IPCC, the inquest verdict, Dr Casale's review and what I
25 would like to do now is to ask you about certain aspects

1 of your lived experiences as Sean's sister in the days,
2 the weeks, the months and the years that have followed
3 his death that perhaps bear some similarity to
4 experiences that Sheku Bayoh's families have had in the
5 years since he died.
6 And I'm hoping that you might be able to help the
7 Chair to the Inquiry by drawing on your experience and
8 sharing your thoughts about what might have been done
9 better, what might have made a difference and looking to
10 the future what might be done differently.
11 And I wonder if we can begin with the night that
12 Sean died?
13 A. Yes.
14 Q. So the evening of 2021 August 2008, and I wonder if we
15 can pull up your statement, please, and turn to page 15.
16 A. 15?
17 Q. 15, please. There isn't a paragraph number, but there's
18 a heading here "initial information given after Sean's
19 death." So I came going to read through this paragraph
20 and then ask you some questions about it. I'll wait
21 until the find the reference.
22 A. Sorry.
23 Q. Not at all. It's page 15.
24 A. Thank you.
25 Q. So it's under the heading "Initial information given

1 after Sean's death."
2 A. Yes.
3 Q. "On the night of Sean's death, my life changed
4 overnight. My family were contacted by police liaison
5 officers on the telephone in the middle of the night at
6 around 2.30 am who wanted to come and speak with us face
7 to face. It was my brother and sister, as I was out of
8 London that evening, so my sister telephoned me. When
9 the two female liaison officers arrived, they told us
10 that Sean had died in Brixton custody, but didn't have
11 much information in terms of how he died, just that he
12 became unwell and suddenly collapsed in Brixton Police
13 Station."
14 Can I just pause there to ask what had happened in
15 the middle of the night? Had you made your way to your
16 brother's house or your sister's house or was it your
17 brother and sister who met with the family liaison
18 officers and then later relayed to you what had
19 happened?
20 A. Yes. So I was Sean's next of kin and -- but that -- so
21 they -- I understand that the police or somebody -- the
22 police went to my house to tell me that Sean had died,
23 but I travelled to Birmingham that morning. I just woke
24 up that morning and just felt I needed to go and visit
25 my father's grave. We're actually from Birmingham and

1 so I just felt to do that and I booked a ticket. This
2 is all just in that morning. I booked a ticket and I
3 went by coach and I went to Birmingham.
4 I arrived at about 7 o'clock that evening. I wasn't
5 feeling too well, strangely. I was feeling quite unwell
6 for the next few hours and later on. That's during the
7 time that Sean was actually dying. That's another
8 story. But basically I was in Birmingham.
9 So the police had contacted my sister by telephone.
10 Now, Sean was only carrying his passport that night,
11 that day. He didn't carry his phone or his keys. So I
12 think they must have went to the hostel to get my
13 contact details. Now, I think my name was on the
14 system, because, like I said, Sean was known to the
15 police, there were times when Sean had been relapsing
16 over the years occasionally and the police would be
17 contacted and he was taken to a place of safety. On
18 this day they didn't do that but -- so they should have
19 had my contact details, my number.
20 Anyway, they didn't and I wasn't at the address.
21 I think I had moved -- just previously moved just before
22 that as well. I moved address and it was Sean that
23 actually helped me to move from that address so I saw
24 Sean about two or three weeks before he died and he was
25 well. I have lost my train of thought. Ask me the

1 question.
2 Q. That's all right. Take a moment.
3 A. Yes.
4 Q. What I was keen to understand was what had happened --
5 A. Oh, yes.
6 Q. -- overnight. You have explained that you had gone from
7 London to Birmingham to visit your father's grave and
8 you were out of London on the night that Sean died and
9 so it was your sister who contacted you.
10 And I was keen to understand whether -- I wasn't
11 aware that you had been in Birmingham and perhaps that
12 is not short journey, but I was keen to understand
13 whether you made it back to London and received the news
14 with your brother and officer or whether what we see set
15 out here, that they were told that Sean had died in
16 police custody, they didn't have much information, he
17 became unwell or collapsed, whether that information was
18 shared with you on in person or whether that was shared
19 with your siblings --
20 A. On the telephone.
21 Q. -- and they passed it onto you?
22 A. My sister received a telephone call. They had got hold
23 of Sean's phone, I think, because my sister happened to
24 phone Sean as well that time -- that day evening at 8.23
25 because it was in my sister's phone. So I think they

1 went to the hostel, they got Sean's phone and they rang
2 my sister. I'm not sure quite sure how they got it, but
3 they rang my sister's number and not mine, and said that
4 they needed to come and speak to her face-to-face
5 because -- about Sean.
6 And my sister she was waiting for them to come to
7 her house, my sister's house, because I wasn't at the
8 address that they knew. So my sister then rang me in
9 the middle of the night. It was about after 2 am she
10 rang me. I was in bed, just gone to bed to sleep, and I
11 got this phone call and I found that strange, because it
12 was like 2.30 or so in the morning. So I answered it
13 and she said I've just got a phone call from the police
14 saying that they need to come and talk about Sean, he's
15 dead, I know he's dead. She just knew. So what I
16 decided to do -- so I waited for her to call me back
17 when they arrived and she called my brother, Wayne, and
18 my sister is Samantha, and my brother went to her house
19 and the police liaison officers went to my sister's
20 house face to face and told them that Sean was -- had
21 died -- suddenly collapsed and became unwell and
22 suddenly collapsed in -- at Brixton Police Station and
23 they didn't know anything else. These were police
24 officers, not liaison officers, not the IPCC or anybody
25 else. They were the ones so, no.

1 So my sister was relaying it to me on the telephone
2 and then I didn't go to sleep. I was calling the rest
3 of my family telling them that Sean had died and I
4 returned to London. First thing in the morning I went
5 to visit my dad's grave which is why I went and I had to
6 put two roses and two cards, one for Sean and one for
7 dad, and what I felt was that my dad had Sean. There
8 was a reason I woke up that morning and just wanted to
9 go to my dad's grave and I lied on the top of his grave
10 and cried and cried and cried and then I took the first
11 train back to London and went straight to the hostel in
12 Brixton where the rest of my family were. So we was
13 asking questions from then, yes. That's what happened.
14 Q. Let's go back to your statement. We had got to the part
15 where you said:
16 "The two female liaison officers arrived. They told
17 us Sean had died in Brixton custody, but didn't have
18 much information in terms of how he died, just that he
19 became unwell and suddenly collapsed in Brixton Police
20 Station. We were not allowed to see or identify Sean's
21 body. That was our first concern, when can we actually
22 see him? Is it Sean? Is he really dead? But to our
23 surprise we were told his body was sealed off in a body
24 bag, that his body belonged to the state and so
25 therefore we couldn't see him. They should and offered

1 his cancelled passport as a way for us to identify him.
2 We found that difficult to comprehend and understand,
3 because it did not prove that he was dead."
4 A. Can I just clarify that this was when I say "we, we, we"
5 I am saying the family, but it was to Samantha and
6 Wayne, my brother and sister, that they went to the
7 house to see.
8 Q. Thank you.
9 A. Yes.
10 Q. "I don't recall if they said that Sean was carrying his
11 passport at the time of arrest. They then handed us a
12 bunch of leaflets because they were asking so many
13 questions, one of which was an Inquest leaflet with
14 quote from Roger Sylvester's family saying along the
15 lines of 'If it wasn't for Inquest, we don't know how we
16 would have been able to get through the inquest
17 process.' From then on, we just didn't trust what the
18 police were telling us. We couldn't access the body.
19 They wanted us to sign a medical release form because
20 the police wanted access to his medical records and they
21 were asking questions like 'Was he ill? Was he
22 suffering from any illness, such as his heart or
23 anything like that?' We contacted Inquest by telephone
24 and left a voice-mail which they picked up first thing
25 in the morning at 9.00 am and contacted us."

1 So I wanted to ask a few questions arising out of
2 what you say in that statement?
3 A. Yes.
4 Q. It goes without saying I'm sure that what you have
5 described here is every family's worst nightmare to
6 receive news that their loved one has died and in
7 traumatic circumstances. Is there anything that could
8 have been done by the family liaison officers to make
9 that news easier to bear for your family? Anything
10 about the method of delivery, the information provided,
11 would anything have made that just a little easier to
12 bear?
13 A. Yes. Well, like I said, I wasn't there at the time when
14 they arrived but, my sister and my brother told me that,
15 you know, they're just -- were blasé kind of thing. He
16 just -- they didn't know why he died or how he died.
17 They had no information. They just came to say your
18 brother is dead and we'll drip feed you with more
19 information. They were more concerned about finding
20 about information about Sean.
21 First of all, I realise now in hindsight they
22 shouldn't have been there. It should have been the IPCC
23 liaison officers, but of course by that time they had
24 not deemed it as an investigation by the IPCC until
25 early the next -- later that morning rather, even though

1 they had had gold meetings. So the police liaison
2 officers didn't know what happened to Sean, but yet they
3 have come to tell us he's dead and they wanted us to
4 sign a medical release form immediately then, trying to
5 get my brother and sister to do that.
6 My brother said that he had recalled seeing, you
7 know, not long before that on the news about the death
8 of Frank Ogboru, where he had seen footage where he had
9 been restrained in the street and so that came to his
10 mind and he said, "but people don't just drop dead in
11 police custody, you know. What happened?" and that's
12 when they said they will drip feed us and they handed --
13 because we were asking questions, my brother and sister
14 were asking so many questions, they wanted to leave, but
15 they were probably there for an hour or two, you know,
16 and they ended up writing some notes in a little red
17 notebook for us, which we still have somewhere, because
18 we wanted to know what the procedure was.
19 They didn't tell us that there was going to be an
20 autopsy, Home Office autopsy. They didn't tell us there
21 was going to be an IPCC investigation. I don't recall
22 any of that. They just wanted to know was he sick, did
23 he have a bad heart or anything like that, which is not
24 nice, you know, that's not nice. And we couldn't see
25 him, you know. The first thing that somebody wants is

1 if your loved one has died, you just want to go and see
2 them, dead or alive, to hug them, to kiss them, you
3 know. That's the first part of the grieving process,
4 but we weren't allowed to because they said that you
5 can't see him, he's sealed off in a body bag. His body
6 belongs to the state and we couldn't understand that.
7 So it was right from the very outset it like, but
8 what's this all about? We didn't know. So my sister
9 while they were sitting there she's on the computer
10 trying to, you know, Google, you know, find out what's
11 going on and my brother is speaking to them. You know,
12 it just didn't make any sense basically. And what was
13 extraordinary was that we couldn't go and see him. How
14 do we know he's dead? And do you know what they did?
15 They produced the passport that they said Sean had
16 stolen and they produced the passport to say you could
17 identify him -- you can identify him from this. That
18 didn't make any sense. That doesn't mean he's dead,
19 I don't know how they had his passport. Well, we know
20 now, because he was carrying it. In fact, they gave us
21 the passport back, not the police liaison officer.
22 Shortly after that, the IPCC returned the passport to
23 us.
24 But then one morning I just remember waking up
25 saying, but hold on that's the main evidence, the

1 passport, and so I -- it became, you know, four years
2 later we returned it. It became part of the exhibit,
3 one of the exhibits, because they gave it back to us.
4 It was extraordinary really. You know, that's just some
5 of the initial things that I can remember. So Sean was
6 dead and they didn't know how.
7 Q. Looking back, do you think it might have helped your
8 family if the liaison officers had been able to give
9 more information, more factual information about what
10 had happened to Sean, more procedural information about
11 what to expect going forwards, an autopsy and things of
12 that sort? Do you think that might have been helpful?
13 A. Absolutely, I don't think they even told us why he had
14 been arrested. They just said he dropped dead. He
15 became unwell, he was dead in their custody and we'll
16 drip feed you more information. Was he sick? Sign this
17 medical release form, because they wanted access to his
18 medical record and to get out of there, get out of the
19 house. And that's cold.
20 You know, if you're a liaison officer you should be
21 liaising with the family, you should be caring, you
22 know, you should be -- you should be familiar as to what
23 death is, because everybody in this room has experienced
24 a death of a loved one, of a family, it's a no-brainer.
25 Q. And looking back, do you think it might have helped your

1 family that night if there had been more compassion,
2 more focus on the family and perhaps less in the way of
3 questions about Sean and his health?
4 A. Exactly, that's the word, compassion, there wasn't any.
5 We were just left in limbo and, you know, there was just
6 more questions and more questions. If he died in their
7 hands, you know, so to speak, in their custody, why
8 couldn't they tell us what had happened? Why was he
9 arrested? Why is he dead? But, you know, there was --
10 that information was not forthcoming. It took months
11 and years to find out actually what happened.
12 Q. Looking back, do you think it would have helped your
13 family if they had been able to see Sean straightaway
14 that night or perhaps the next morning? Would that have
15 helped them to come to terms with the reality of his
16 death and begin the process of grieving?
17 A. Yes. Well, we did get to see him on the Saturday, two
18 days after his death so -- of course it was in the
19 middle of the night. We was gathering the family on the
20 telephone, you know, my other siblings and of course we
21 would have gone -- we would have gone first thing in the
22 morning to go and see Sean. Is he really dead?
23 You know, it was a day that we was worried that
24 might happen one day anyway, because, you know, he
25 suffered with mental health for 20 years and he relapsed

1 and sometimes Sean would actually go abroad. And most
2 of the time he was well, but sometimes he would relapse,
3 but we thought maybe -- and the mental health team
4 didn't tell us he was abroad, things like that and so we
5 were concerned that one day we might get this phone call
6 that he had -- he had died.
7 And so we were just in investigative mode
8 immediately with all these questions and I think most
9 families would ask the same -- anybody would. Where is
10 he? When can we see him? And they were obstructing all
11 of that and so from the very outset we were concerned
12 even though we had a fair amount of trust in the police,
13 you know. We didn't know about deaths in custody, that
14 police kill people, so we wasn't on that radar. We just
15 wanted to know what happened in Brixton Police Station.
16 Q. Can I ask this lack of compassion, lack of information,
17 greater interest in questioning the family about Sean,
18 no opportunity in the immediate aftermath of his death
19 to see his body, what impact did that have for the
20 family in terms of their relationship with the IOPC from
21 that -- with the police and the IOPC from that point
22 onwards? You say in your statement "from then on we
23 just didn't trust what the police were telling us."
24 A. No.
25 Q. What was the impact, what damage was done by the way

1 those initial conversations were managed by the
2 liaison --
3 A. What do you mean "damage"? Damage to who?
4 Q. To the relationship that you might otherwise have had
5 with the authorities, what was the impact on that
6 relationship?
7 A. We didn't trust the police for a start off. You have
8 got his passport. You didn't say he had been arrested
9 for stealing it. You're just showing it to us as
10 identification. The lack of compassion. So you know,
11 we didn't trust them anyway. They didn't tell us about
12 the IPCC. It's just they handed a bunch of leaflets and
13 my sister saw this one and called Inquest. It was
14 about, you know, in the middle of the night, 3 o'clock
15 or whatever time it was.
16 They called back and they were the ones -- Inquest
17 were the ones that said by the way there's going to be
18 an autopsy and there's going to be an IPCC
19 investigation. We had never heard of the IPCC. So that
20 was the introduction of them of the IPCC and Inquest had
21 contacted the IPCC who then called us. So the
22 investigator was somebody called Christopher Partridge,
23 who said we met them on the telephone and we wanted to
24 stop the autopsy, halt it. It was Bank Holiday weekend,
25 Carnival weekend, and we wanted representation at the

1 autopsy. This was the advice from Inquest. We didn't
2 know what to do. All we wanted to do was to see him and
3 we couldn't do that, so the next step was that we found
4 out there was going to be an autopsy, but we hadn't
5 identified him yet. So that was strange.
6 And so then the IPCC said we couldn't see him, that,
7 yes -- so we had stopped the autopsy in the morning
8 trying to get hold of somebody called Nat Carey, trying
9 to find a pathologist that our solicitor Hickman & Rose
10 and Inquest advised us to look for. We couldn't get
11 hold of anybody so the autopsy went ahead regardless,
12 the Home Office autopsy went ahead regardless that
13 afternoon, and then -- so we were waiting to find out
14 how he died. We thought we would find out then.
15 So this is Friday, the very next day, the 22 August,
16 the very next day, and then we were on the phone with
17 IPCC who then said they didn't know how he died. His
18 death was unascertained. They told us there were like
19 superficial injuries, none of which had caused his
20 death, and then so we were more puzzled, you know.
21 In between that time, we had also were going to the
22 hostel, asking them questions and we found out that
23 there was going -- there was 999 calls to the police ...
24 (12.39 pm)
25 (YouTube feed frozen)

1 (Luncheon adjournment)
2 (1.55 pm)
3 LORD BRACADALE: Ms Rigg, I am very sorry we had to adjourn
4 so abruptly before lunch, but the proceedings are being
5 broadcast, as you know, and there was a fault with the
6 system. That's been resolved so we're now able to
7 proceed with your evidence.
8 A. Thank you.
9 LORD BRACADALE: Ms Thomson.
10 MS THOMSON: Thank you.
11 We were talking about the occasion on which you and
12 you are family members visited the mortuary on order to
13 see Sean's body. This of course was the point at which
14 the system crashed and let us down, so I wonder if it
15 might be helpful just to bring your statement up on the
16 screen again so we can get back to where we were before
17 we had to take a break.
18 A. Yes.
19 Q. So we were looking at the page that has paragraphs 21,
20 22 and 23 on it. If we could perhaps look at 22 and 23.
21 I read these over to you before the break, so I can
22 perhaps read them short, but in paragraph 22 you stress
23 that you weren't able to touch or hug Sean, because he
24 was behind a screen in locked room. You could only view
25 him through the glass window after a curtain had been

1 pulled back and you could only see one side of his face
2 and he was in a body bag.
3 And you go on to explain in the paragraph that
4 follows in 23 that effectively, but for your insistence,
5 that would have been the extent of your viewing of his
6 body, but the family insisted and eventually the powers
7 that be relented and you were allowed into the room with
8 him and discovered to what you describe as the horror of
9 the family that there were injuries to the other side of
10 Sean's face that you hadn't been told about. And that
11 essentially is where we were at before we had to take an
12 untimely break.
13 I wanted to ask you what had been done to prepare
14 you and your family for the experience of viewing Sean?
15 Had you known in advance that he would be behind a
16 screen, had you known in advance about the body bag, had
17 you known in advance about the extent of his injuries,
18 had you had expectations that you would be able to
19 approach him, touch him, kiss him, hug him? To what
20 extent do you feel that you had been prepared for the
21 experience?
22 A. I don't recall that we were prepared for anything. We
23 knew that he had an autopsy, we knew that he was sealed
24 off in a body bag, whatever that meant at the time, you
25 know, but we thought we would be able to hug him and

1 touch him like anybody else whose loved one had died so
2 it was very similar to the room across there that you
3 could look through a glass window, so it had curtains,
4 I think they were green. And so we went into the room
5 and the curtains were pulled back and he was just there,
6 but he was behind the glass. I thought the curtains
7 might have been so that you could just go in, but he was
8 behind glass.
9 He was seized by the Home Office literally and it
10 was devastating. I fainted and, of course, it was Sean
11 and he was dead and, you know, it was the realisation of
12 seeing his body, which was not nice, but then one of my
13 brothers said we need to go inside to see the other side
14 of his face and so we -- there was the IPCC there and
15 the mortuary staff and they said, no, because of his
16 dignity and we thought what dignity? He's already dead.
17 And, reluctantly, it was opened, but I remember it being
18 a big long rod. He was bolted behind this room. It was
19 a rod that was pulled back and then we went in and then
20 we saw the injuries.
21 There were injuries here, two injuries here and we
22 were like, why didn't you tell us about that? They were
23 watching us, Christopher Partridge, Richard Omotosho and
24 Geraldine. It was just awful, because we were not told
25 about those injuries to his forehead. We were told

1 there were superficial injuries like to his wrist,
2 consistent with handcuffing, grazes on his elbows and, I
3 can't remember, knees and I think his foot, but nothing
4 about a restraint. You know, we had never seen his
5 body. We did eventually see the autopsy pictures, which
6 showed more injuries on his body, but we were told about
7 this, two injuries here. So I remember my brothers
8 turning their back. We were just, you know, faced with
9 death, because it was our brother. Anyway.
10 I recall putting my hand across his body from the
11 top down to his feet so I could feel his body. I think
12 they were looking at me quite horrified, because I think
13 they might have been thinking I was pulling the zip
14 back. The only reason why I didn't do that was because
15 he had had an autopsy. We were told he had had an
16 autopsy and so I didn't do that, but we kept saying, why
17 didn't you tell us about those injuries? And they
18 didn't -- I don't recall them saying anything. We had
19 friends with us who were taking notes and I wanted to --
20 I said to my brother-in-law get the camera, get the
21 camera. And then I think I asked them, were there
22 photos taken? And they said they were so I left it. I
23 wish I had actually taken those pictures so everybody
24 could see what it was like when your loved one dies in
25 state custody, the body is seized in a locked room.

1 I also recall reading -- a bit off the question, but
2 I remember reading Doreen Lawrence's book, very early
3 stages my friend lent me her book, and I recall her
4 saying something about viewing Stephen's body and she
5 just wanted to be left alone. The family wanted to be
6 left alone so they could be with him and I remember that
7 and it was very much the same for us. But most families
8 wouldn't ask to go inside that room, you know. It was
9 just one of my brothers that said it and if he didn't
10 say it, I don't think we would have ever went in the
11 room and we would not have known about the injuries
12 until we saw the autopsy photos so, yeah, that was --
13 that was awful, and this was just two days after,
14 Saturday, 23rd August.
15 Like I said earlier, they didn't want us to see the
16 body until six days after, but we were able to see him
17 on the 23rd and from then, we just never stopped. Never
18 stopped -- we were angry, we were angry, we were hurt.
19 My brothers turned their back towards the wall, because
20 they just couldn't look at him and that's when of course
21 we knew that it was Sean and he was dead. Still. He
22 was still. He was -- I kissed him on his forehead and I
23 left my lipstick print on his forehead. I remember that
24 that bit and I remember -- yeah.
25 Q. You said that what you wanted as a family was to be left

1 alone with Sean. Were you given that opportunity? Did
2 the IPCC and the mortuary staff retreat and give you
3 privacy or were there people in the room with you?
4 A. I said I remember reading in Doreen Lawrence's book,
5 "And still I rise it's called", that she talked about
6 viewing Stephen Lawrence's body in her book. I can't
7 remember exactly what it all said, but I remember now,
8 as I am speaking to about it, that she just wanted to be
9 alone. They wanted -- her and her husband, Mr Lawrence,
10 wanted to be alone with their son, so they could look at
11 his body, look at him and that's what we wanted to do.
12 So I can't remember if he was in a locked room. I don't
13 remember if she said that. I just remember when they
14 went to view the body and reading that. I'll go back
15 and read that segment again actually.
16 But they did not -- for us, the IPCC were in the
17 room, not in the actual room, they were watching across
18 the room while we went inside the room. It was open for
19 them to see. So they were watching us. They didn't
20 leave us alone at all, no.
21 Q. Looking back, do you think it might have helped your
22 family if the IPCC had done more to prepare you for the
23 experience of viewing Sean's body? If they had perhaps
24 told you that there would be a screen, that he would be
25 in a room with a bolt on the door, that he would be in a

1 body bag and made you aware of the extent of his
2 injuries, if your expectations of the experience had
3 been managed in that way, might that have been helpful
4 to the family?
5 A. Yes, they may have done when we arrived. When we
6 arrived and -- because we didn't go straight in. We
7 went into a little room. I think it was at that stage
8 they wanted to know the next of kin and, you know, they
9 told us that we were going to have an interim death
10 certificate. They may have also said at that time that
11 he would be behind, you know, a glass room, they may
12 have said that.
13 So when we first went in, we were there -- we was
14 with him, you know, for a little while. I remember I
15 fainted and we were just crying and I can't remember
16 everything and then after a little while -- after about,
17 you know, say 10, 15 minutes or so then we asked to go
18 into the -- for them to unlock it so we could go inside
19 the room to touch him, to hug him, to see the other side
20 of his face and they were reluctant for us -- to allow
21 us to do that. But I realise now, you know, I think the
22 family has a right to do that, because they did open it,
23 you see. But it's only because we asked and then when
24 one of my brothers -- we said "yeah, yeah, open it, open
25 it," he went ballistic, "open it", and when we saw the

1 injuries it was like, okay.
2 Q. Looking back, do you think it would have helped your
3 family if you had to had the opportunity to see Sean and
4 touch him, kiss him, say good-bye to him before the
5 autopsy took place?
6 A. Definitely, definitely. How dare they? We have never
7 seen Sean's body. You know, his body belonged to us,
8 his mother, not to them, not to the Home Office and so
9 they should have allowed us to identify -- they could
10 have given an autopsy to somebody that wasn't Sean Rigg.
11 They must have known it was Sean Rigg, they knew it was
12 him, but at the time, in those few days, they wanted us
13 to identify him from the passport. They had his
14 passport. They had it on the night. You see it in the
15 custody CCTV. It goes all round. They're all looking
16 at it.
17 They knew, but why didn't they tell us about those
18 injuries? They never have to this day. We don't know
19 how they got those injuries to this very day. We don't
20 know. The officers said later that they received the
21 injuries when they were putting him in the van after the
22 restraint it is their training to hold their head down
23 so they don't bump their head and they didn't do --
24 excuse me -- and that they didn't do that and that's how
25 he bumped his head. That's what the officers said, but,

1 yeah ...
2 Q. Again, looking back, do you think it might have been
3 helpful for your family if you had been afforded more
4 privacy, if you hadn't had the IPCC watching you through
5 the window in the room?
6 A. Most definitely, most definitely. The window had been
7 opened by that time, because it was a rod and -- I can't
8 remember. I can't remember if the window -- I think it
9 was a rod and we had to squeeze around the bed that he
10 was lying on, because it was so close to the window, the
11 rest of the room was behind, so we all had to go around
12 and then we was all behind and that's where we saw the
13 injury and then that was just something else, because we
14 were not told about those injuries.
15 It was just two small, you know, like thumbprints
16 round, you know, a bit little like what a metal asp
17 looks like. It's got a little ball on the end. I'm not
18 suggesting that's what it was at the time we did, but we
19 don't know how he got those injuries, apart from the
20 accounts of the officers that he bumped his head whilst
21 being put into the van.
22 Q. Can we look at paragraph 51 of your statement now,
23 please.
24 A. I think if we had more time with him, you never know,
25 might have pulled back that -- pulled it back. I wanted

1 to see his body, you know. We didn't have that
2 opportunity because he had had an autopsy.
3 Q. And what impact has that had on you and your family that
4 you couldn't see Sean's body?
5 A. You know, that's not right, but I can't get that back.
6 you know. When we did eventually have access to his
7 body, he was decomposed. So they gave us back a very
8 decomposed body, seven weeks later for burial so at
9 least we had that opportunity to see his face, what he
10 looked like, how we expected to see him. But when we
11 next saw him, we never saw his body and he was seriously
12 decomposed. It was worse. Yes.
13 We were told and the IPCC didn't tell us that, you
14 know, when they gave the body back for burial. They
15 wanted to give us back his body a week later actually, a
16 week later after the autopsy, and we said no because by
17 that time we wanted an independent pathologist, because
18 we saw those injuries and so Sean's body was kept back
19 for another five, six -- five weeks or so before we had
20 our own independent pathologist who was Peter Vanezis.
21 When he went to conduct that autopsy, Sean's heart
22 and brain was not in his body and we were like why
23 didn't the IPCC tell us that and we were absolutely
24 furious, which I think that if they had given us Sean's
25 body back a week later, he would have been buried

1 without his heart or brain. And I know that's what
2 happens to other families and other families have told
3 me that. So we were furious.
4 We also wanted -- requested that the IPCC and the
5 coroner kept back any slides from the autopsy, anything
6 that was kept for toxicology, toxicology reports and so
7 on. In fact, saying that, I remember when we first had
8 our meeting with the IPCC they were asking us, does he
9 take drugs? I said, no, categorically he doesn't take
10 any drugs, and that was proved by the toxicology
11 reports, you know, when it was available later. It
12 wasn't but -- on the night they were talking about drugs
13 on the CCTV, or I do believe he's taking drugs and the
14 FME was told that, you know, he's having a heart attack
15 with drugs. Where did they get all that from? He
16 doesn't take drugs. And there's other things I could
17 say as well but, you know.
18 Q. Let's look at paragraph 51, if you could perhaps scroll
19 down to the section headed "Return of Sean's body" where
20 you say a little bit more about your discovery that his
21 heart and brain had been removed. You say:
22 "Another thing that was very upsetting is that
23 following the autopsy, the IPCC wanted to return Sean's
24 body to the family you burial a week or so later but we
25 refused. We were able to finally instruct

1 Professor Peter Vanezis as our independent pathologist
2 about five weeks after Sean died. We've learned Sean's
3 heart and brain had been removed during the first
4 autopsy, but this was the first time we knew about that,
5 five weeks later."
6 And if I understand your evidence correctly, it was
7 as a result of Professor Vanezis' performing his autopsy
8 that it came to light that the heart and brain had not
9 been returned to Sean's body?
10 A. Yes, that's how I remember it.
11 Q. What impact did that have on you and your family?
12 A. I can't tell you. It was so traumatic. Of course we
13 wanted to bury Sean with all his body parts, you know.
14 What were they doing with his brain and what were they
15 doing with his heart? Where was it? Where was it,
16 number one? And number 2, get it back. And when we
17 were -- when Sean's body was returned seven weeks later
18 for burial, we checked with the funeral undertakers to
19 make sure his heart and brain was intact and they said,
20 yes, it was.
21 I just hope it was Sean's heart and Sean's brain.
22 You know, who knows what they did with it. But when
23 Peter Vanezis conducted his autopsy, his brain and heart
24 was not there and, obviously, he needed it to conduct
25 his own autopsy you see. So that's why we found out and

1 of course they had to get it wherever it was, the IPCC,
2 they had to get it, or the Home Office, whoever it was,
3 get it, yes.
4 Q. I wonder if we might move to talk about another aspect
5 of the case now?
6 A. Yes.
7 Q. Take a pause, have a glass of water, if that might help.
8 And while you're taking a moment, I wonder if we can
9 bring up the Casale Report again on screen, please,
10 because I would like to take you to --
11 A. Could I just add one thing?
12 Q. Yes, of course.
13 A. I beg your pardon for interrupting.
14 Q. Not at all.
15 A. You know, when I talked the slides, I don't know if I
16 said also that what happened in the end we found out
17 years later that the IPCC threw those slides away, threw
18 away the slides. There was something very important.
19 I think I will actually say it.
20 On the night, when the paramedics arrived, they
21 wrote their initial notes -- does this mean we've not
22 gone live?
23 Q. No, don't worry. We are just between documents. Don't
24 worry. Someone will tell me if there's a problem with
25 the live feed.

1 A. Yes, I recall them writing. When they arrived at the
2 police station, these are the paramedics that arrived at
3 8.36, Sean was asystole and they were trying to
4 intubate, you know, the tube, the drip and she said --
5 she wrote "There was a hard white-like substance stuck
6 in Sean's throat" so she couldn't do it through the
7 throat. She did it -- they had to do it a different
8 way. Okay, that was number 1. Number 2, at the
9 autopsy, the original Home Office autopsy, whatever
10 substance was there was removed from his throat to send
11 for testing, if I remember all of this correctly. This
12 is how I remember it. There was five CID officers
13 within Sean's autopsy and the pathologist, nobody
14 representing the family, and they made handwritten notes
15 of which we have those notes and it was somebody called
16 Simon Couzens who was an ex-police officer who was now
17 with the IPCC and he wrote on his notes "unlawful
18 killing" and then he wrote something really tiny
19 underneath which you can't read, and he could never read
20 it back either when we asked years later for him to
21 transcribe it. And he also wrote "cocaine?" and, yes.
22 So when it was near to the inquest we wanted the
23 swabs back, you know. What was actually in his throat?
24 And it was thrown away by the IPCC on the basis that
25 they didn't think it was of relevance, even though the

1 family had requested that all sides be kept back,
2 because we even contemplated exhuming Sean's body as a
3 family, but we didn't want to have to do that, but it
4 was a contemplation that we would do and that's why we
5 wrote to the coroner and to the IPCC just to make sure
6 everything was intact. So we just thought that was
7 there, but it wasn't when we came so -- because Sean
8 didn't take drugs, you see. So whatever was there, how
9 did it get there?
10 And I have never said that in public, but I'm saying
11 it to this Inquiry. That is what happened.
12 Q. Let's just take a moment and we can perhaps in a moment
13 or two bring up the Casale Report again and if you feel
14 able to continue at this junction with your evidence, I
15 appreciate we have been talking about some issues that
16 are very, very difficult for you to revisit?
17 A. Yes, I might to add as well, just quickly, that
18 paramedic when she was eventually interviewed by the
19 IPCC, she changed her evidence and said it was foam,
20 froth there, yes.
21 Q. Thank you.
22 A. So her actual paramedic notes, her first record said
23 hard white-like drug substance or something like that
24 and then it became "froth".
25 Q. I wonder if we can turn to look at a completely separate

1 issue now and if we could perhaps bring up page 12,
2 which I think will be 19 of the PDF. And this was to do
3 with your relationship with the police and the IPCC in
4 their report had noted that the issue of police family
5 liaison was not part of their terms of reference and
6 therefore wasn't investigated. The IPCC went to say:
7 "Suffice to say that if the family's recollections
8 of the hours following Mr Rigg's death are accurate,
9 then they did not receive the service that perhaps they
10 could have expected."
11 And the issue of the family's relationship with the
12 police and with the IPCC was touched on by Dr Casale and
13 there are two paragraphs here that I would like to read
14 out and then ask you some questions about them. So we
15 see here on the screen:
16 "The review was concerned to find that the IPCC
17 documents include Police National Computer records for
18 two members of Mr Rigg's family. The IPCC had requested
19 the PNC records relating to the main witnesses to the
20 arrest, but not for the Rigg family, who did not witness
21 the events surrounding Mr Rigg's death. The review has
22 not viewed the content of these records and considers it
23 inappropriate for this information to have been sent by
24 the Metropolitan Police Service to the IPCC. After the
25 death of Mr Rigg, his family should have been considered

1 as akin to victims, as should the family of any person
2 who dies in custody, unless the family is involved in
3 the events leading to the death.
4 "In order to avoid unjustified provision of
5 confidential information from the NPS to the IPCC, any
6 such material sent to the IPCC should be sent back with
7 a request for an explanation of the action and a clear
8 indication that the IPCC considers it inappropriate to
9 receive such information.
10 "It appears that the senior investigator viewed the
11 PNC records of two members of the Rigg family in the
12 context of a risk assessment related to the family's
13 viewing of the Brixton Police Station CCTV. On the
14 information available to it, the review considers that
15 it was not necessary or proportionate for the senior
16 investigator to view the contents of the PNC records of
17 members of the Rigg family in this context. Data held
18 on the PNC will almost invariably amount to sensitive
19 personal data. The review fails to see the relevance of
20 processing the sensitive personal data of members of the
21 Rigg family. Such processing may have been in breach of
22 data processing principles."
23 A. Yes.
24 Q. And I want to ask you about this. Can you tell me how
25 and when the family became aware that PNC information --

1 information from the PNC was in amongst the IPCC papers?
2 A. Yes, absolutely. I forgot about that actually, yes. Do
3 you remember I told you earlier that we were able to
4 gain access to the IPCC's offices --
5 Q. Yes.
6 A. -- at some point during a pre-inquest review and the
7 family weren't allowed to go, but our solicitors did and
8 so all the files were brought out. There was a cabinet
9 called "unused material". It was in there. That's how
10 we found out. And we were furious, because they were
11 investigating the family. It was my two brothers PNC
12 records, whatever they contained I have no idea.
13 When we went to view the footage at the IPCC's
14 offices of the CCTV, within a few weeks -- it was like
15 about three, two, three weeks after Sean's death, when
16 we saw what was happening on the footage, of course we
17 were angry, of course we were angry. Why aren't you
18 interviewing the officers? Look he's dead, he's dead,
19 because he was so collapsed as soon as he came into the
20 station, into that -- into the -- at the entrance of the
21 custody suite in a caged cell, you know.
22 A lot of the media say that he was taken to a
23 holding cell. He was not inside the station, it was
24 outside. It was a cage, another cage. He was in a cage
25 in the van and he was in a cage in the yard of the

1 station. And that's where he was caught on CCTV as
2 clearly collapsed. He just wanted to sleep.
3 A violent man coming in at Brixton Police Station,
4 one of the most notorious stations in London, was
5 allowed to just sleep. Really? He was obviously
6 collapsed so we were concerned about that. And then
7 I think they were concerned about community unrest,
8 riots, because we had seen gold minute notes. Yes, so
9 they were surveillancing the family.
10 What on earth were they doing with my brother's PCN
11 records? They're not criminals.
12 Q. Were you ever given an explanation by the IPCC for why
13 they held that information?
14 A. No, I don't think so and I don't think we ever got them
15 back, no.
16 Q. What was the impact on your family of that discovery?
17 A. My brothers were furious. My brothers were furious,
18 because they were investigating the family and not the
19 police officers. The police officers were being treated
20 as witnesses. Sean wasn't there -- I mean my brothers
21 weren't there, Wayne was the client, and why did they
22 have their records? You know, that's another question
23 I would like to ask the IOPC today. Where are they?
24 Yes, thank you for reminding me of that.
25 Q. Again, can I move on and ask you about another subject.

1 I would like to ask you some questions now about the
2 media and information that was put into the public
3 domain I understand on an anonymous basis. Let's
4 perhaps begin by looking at paragraphs 38 and 39 of your
5 statement.
6 A. Yes.
7 Q. "We knew be the Saturday that Sean died at the station
8 and that the IPCC's press release that day was not all
9 factually correct. The press release said that Sean had
10 assaulted an officer, not alleged assault, and that was
11 pronounced dead at the point at 9.24 pm where he had
12 subsequently died, which was not true. I don't believe
13 we knew about the press release before it went out and
14 what it said. I'm not sure if Partridge realised I
15 worked for a niche libel and litigation firm at the time
16 in the City of London. At our first official meeting, I
17 threatened him and the IPCC with a libel action, because
18 some of the information was not true. They subsequently
19 apologised publically and agreed to remove and correct
20 the mistake with a public apology. They amended their
21 statement on their website.
22 "Within days of learning about Sean's death we faced
23 numerous obstacles, but these are just some of the
24 initial ones. It became worse as time went on, so our
25 campaigning and the charity Inquest was even more

1 vital."

2 So you describe here information being put into the

3 public domain that simply wasn't correct, particularly

4 in relation to there being a statement that Sean had

5 assaulted an officer rather than allegedly had assaulted

6 an officer and that he died in the hospital which as you

7 say was not. True?

8 A. There was something else as well that they said that

9 wasn't correct, but I can't remember what it was.

10 I would have to -- I think apology is still on the

11 IPCC's website today and it might tell us what it is,

12 but the original -- the offending press release dated

13 23rd August you won't find it on there, but I do have a

14 hard copy at home. I know exactly what it said, yes.

15 Q. It may be that we can find it on the --

16 A. Thank you very much.

17 Q. -- the IPCC, IOPC website.

18 A. Yes.

19 Q. Now, in relation to the information that was put into

20 the public domain, we've heard evidence from a

21 Professor Meer at Glasgow University and he commented on

22 this and he said that what he thought was important was

23 what was omitted from what was put into the public

24 domain. He said:

25 "I think what is omitted is as important as what is

1 stated. Sean was a vulnerable person in a mental health
2 crisis and he should have been the object and subject of
3 care, but he was presented as a criminal presenting a
4 clear and present threat to the public."
5 A. I think they were saying he was being violent.
6 Q. Yes.
7 A. Yes.
8 Q. Yes. And we also heard evidence from Deborah Coles, at
9 Inquest, she was speaking in general terms and not with
10 reference to Sean's case in particular, but she said
11 that what happens when these media releases go out is
12 they create in the public mind the idea of an
13 undeserving victim and when that information enters the
14 public arena, it's very difficult to challenge it. You
15 are nodding. Would you agree with what Ms Coles said?
16 A. Absolutely. One of the things that we kept seeing in
17 the public domain was that Sean had a heart attack. He
18 didn't have a heart attack. His heart -- he was a fit
19 and healthy man. That he was found in the inquest. We
20 knew that as a family. He was fit and healthy. He only
21 suffered with schizophrenia, which does not kill you,
22 and -- sorry. Can you repeat the question?
23 Q. Give me just a moment. I don't have the live feed in
24 front of me. Bear with me just a second, thank you.
25 A. Oh, about what was in the press release.

1 Q. Yes.

2 A. Yes.

3 Q. I had taken you through what Professor Meer had to say
4 and what Deborah Coles had to say. Is that sufficient
5 to trigger your memory where you were?

6 A. Yes. So they were saying that he had a heart attack,
7 which I don't know where that came from, probably the
8 police or the IPCC, because we didn't tell them that.
9 He was fit and healthy. Sean died of a cardiac arrest,
10 which means that his heart stopped. Everybody has a
11 cardiac arrest when they dies, because the heart stops.
12 It doesn't necessarily mean that you had a heart attack
13 or there's something wrong with your heart.

14 So that was some of the statements that were going
15 out that he was a violent man, nothing about him
16 suffering with mental health. I'm talking in the very
17 early stage. There was about two or three press
18 releases that went out. I'm talking about the one on
19 23rd August, which was the day that we went to visit to
20 identify Sean's body, Saturday, but I think they had put
21 something out on the -- you know, in the early hours of
22 the 22nd of August. I can't remember what they said,
23 but you won't see them there now. They have been
24 corrected.

25 Once I threatened them with a libel action, they

1 quickly took it down, because it was libel. It was
2 libelous, because they said he died -- he subsequently
3 died at the hospital. That was a lie. They said that
4 he had assaulted an officer, not allegedly, which turned
5 out that the officer wasn't injured. He didn't need to
6 see a doctor. You know, Sean was a karate expert. If
7 Sean had punched the officer, the officer would have
8 known about it. He was not injured and there's no
9 medical evidence to show that. You can see him on the
10 CCTV on the night as well.
11 Q. And in relation to the statement that was put into the
12 media that Sean died not, why was that inaccuracy -- why
13 was that misstatement, that error, why was that so
14 important to the family? Why was it so important to
15 correct that particular information?
16 A. Because we knew he died at the station, you know, when
17 we -- I don't think we have gone on to say that when --
18 after identifying Sean's body, we went straight to
19 Brixton Police Station and we were invited in by
20 somebody called Ma'am Susan Wallace, who was a chief
21 inspector, and she told us he died at the station. She
22 took us to the spot where he had died. So at that time,
23 we knew he had died at the station.
24 The IPCC didn't know we had been inside the station.
25 This all happened on the same day as the press release.

1 They didn't know we had been to the station and we had
2 actually recorded the caged area and we knew about the
3 cameras and so why -- so why were they saying he died at
4 the hospital -- subsequently died -- he became unwell
5 and subsequently died at the hospital. And that's why
6 the jury crossed out "King's College Hospital" and put
7 "Brixton Police Station". It was very important to the
8 family, because that's where he died. That's where he
9 died. So we have a memorial tree there. We were
10 putting flowers there, because that's where Sean died.
11 Q. Did the family have any concerns that the statement that
12 was put into the media to the effect that he died in the
13 hostel might distance the police from --
14 A. Yes.
15 Q. -- their actions and any responsibility or culpability
16 on their part? Was that a concern that the family had?
17 A. Undoubtedly. Because, you know, they were saying that
18 Sean was being violent in the street, but when he came
19 to the station he was well. I don't know what they were
20 going to say at that time. Whether they were going
21 to -- I don't know -- I don't know what they were going
22 to say that like happened, but I think we just got in
23 too quickly and they had to switch. Whatever they were
24 going to say, they had to switch it, because he never
25 entered the custody suite.

1 So I think it said something like he became unwell
2 and then he suddenly collapsed where they called the
3 paramedics -- where and he was taken to the hospital
4 where he died. That was not -- that was libelous.
5 Slander. That didn't happen and that's why it was
6 removed, because it was true.
7 Q. Can I take you back to Deborah Coles' evidence and
8 something that she said.
9 A. Yes.
10 Q. She said:
11 "Families have regularly reported that before the
12 involvement of the independent investigation has
13 started, the police force has very quickly sought to
14 defend its position by releasing their narrative about
15 events to the public before the basic facts have been
16 established. The family has highlighted that
17 misinformation about such contentious deaths not only
18 damages bereaved people, but it also undermines public
19 confidence in authorities. Misinformation following
20 contentious deaths makes it hard to allay any suspicion
21 of wrongdoing and failures in the minds of bereaved
22 families and the public at large. As well as obscuring
23 the picture of what happened, misinformation fuels fears
24 that the state is attempting to deliberately prevent
25 information about its own culpability in deaths become

1 publically known."
2 And again, I see you're nodding agreement.
3 A. Yes, I completely agree and the perception of the public
4 is that's what they remember, what was first put out in
5 the public domain. He was violent, attacking people, he
6 assaulted an officer, but suddenly he collapsed and died
7 at the hospital. Rubbish, absolute rubbish and I make
8 no apology to say that, because they admitted it and
9 took it down, yes.
10 Q. I wonder if we might move on to another topic. I would
11 like to look with you at the future test and let's again
12 go to your statement, first of all, and I will ask you
13 some questions about things you have already said to
14 the Inquiry in your statement. I wonder if we can look
15 at paragraphs 126, please, and 127:
16 "Racism and recommendations.
17 "I have been asked about recommendations from the
18 reports I have contributed to lessons and if lessons are
19 learned. Once the reports and the evidence are laid out
20 bare, from Scarman to Macpherson to Casey, nothing
21 changes about racism. It's just repetitiveness and
22 business as usual, because what we see is that
23 government officials just keep changing seats like
24 musical chairs. They just keep swapping around and we
25 are back to square one. Then there's yet another

1 investigation paid by the tax payers' pocket while the
2 injustice just keep on keeping on and the previous one
3 is shelved, accumulating dust underneath the cobwebs and
4 the lessons are never learnt. Denial and business as
5 usual. The musical showcase is a circus full of chairs
6 and benches, but what will the next government do?
7 "But my issue is this. What more training does a
8 person need to understand the fact that if you restrain
9 somebody like that, suffocate them, what training do you
10 need to know that that person can die after? You're
11 going to prison for murder, but not if you're a police
12 officer. What amount of training do you actually
13 acquire? The issue is, oh, they need more training.
14 They have been trained. They're trained to deescalate
15 the situation, give the person space, a vulnerable
16 person space, but they all jump in. Now it may be that
17 initially the person does need to be restrained. They
18 may be a threat to the public or themselves, we
19 understand that, but it's the method of restraint that
20 is used all the time, particularly of black men, the
21 excessive force. I hear officers give evidence how they
22 were sweating because this person was so strong. It
23 took X number of officers on one person. We're not
24 badder or stronger or madder than anybody else, but the
25 perception of us is that we're dangerous and we have got

1 super human strength."

2 If we might also, please, look at paragraph 133 and

3 134. And here you say:

4 "All these reports have shown it time and time again

5 for decades and yet they keep saying lessons will be

6 learnt and we need more training. It's time to learn

7 want lesson. I know it's hard to hear sometimes, but

8 it's the truth. The truth will set you free. The truth

9 is like oil on top of water. You can try to muddy the

10 waters up, but the oil and water doesn't mix, so the

11 truth will always prevail, always, but they just deny it

12 and ignore it and stay unconscious. It's time to wake

13 up. It has to be done. It's important to be done,

14 because it's important to record it. It's important for

15 the future generations. It's important to make change.

16 It's corporate institutional racism because they just

17 won't do anything about the recommendations. They keep

18 saying, well, what can we do? Make people accountable.

19 That's it. That's the answer."

20 And I wondered if you had any thoughts as to how we

21 might achieve accountability. What might accountability

22 look like, looking to the future?

23 A. It's just so simple. Look at the evidence and when

24 there's evidence of wrongdoing, then they should be made

25 accountable. I don't know how else to put it. But of

1 course the evidence is always in a death in custody in
2 my experience, certainly my experience and from what I
3 hear from other families and the evidence, the facts,
4 it's for decades that, you know, the evidence is tried
5 to change from the actual truth but if you just take the
6 evidence from the actual truth, it's obvious and that
7 person should be made accountable and I don't know quite
8 what else to say because otherwise -- you know, what we
9 need to be doing is to be saving lives but what's
10 happening is that lives are being destroyed, families,
11 and for no reason, for no good reason. And we need to
12 look at the past in order to address the future. The
13 answers are there. There's nothing more that we can
14 actually do. The answers are there; the recommendations
15 are there; the reports are there; the facts are there;
16 the reviews are there. It's all been done. We don't
17 have to do anything. Just do the right thing and make
18 them accountable. But the state doesn't. They can act
19 with impunity.
20 Q. And when you say that individuals who -- against whom
21 there's evidence of wrongdoing should be made
22 accountable, do you mean that due process of law should
23 be followed, that there should be a prosecution or
24 potentially misconduct hearings depending on the
25 evidence that is available? Is that what you have in

1 mind or are you thinking about some other form of
2 accountability?
3 A. Well, that's exactly what I mean. You know, they should
4 be -- whether that's prison or gross -- or gross
5 misconduct, they should be sacked, yes, that's correct,
6 there's no other answer for that. But at the same time
7 we also need restorative justice. So if they're not
8 going to make them accountable, how are you going to
9 restore the -- how are you going to repair the damage
10 that's been caused? Reparations. That's what
11 reparations is. It's not just a monetary term; it's
12 also a physical term. How are you going to repair the
13 damage and the trauma and the impact to the community?
14 So there's restorative justice too. How do you repair
15 the damage? If one police officer goes to prison,
16 that's not going to change anything, not at all. The
17 loopholes, there's so many loopholes that they can use
18 and it's very rare to even get a prosecution, very rare,
19 and so we have that to challenge. There's nothing to be
20 done, because we've done -- the work has been done.
21 What you need to consider is how do you repair the
22 damage that's been done and restorative justice is a
23 way. So you need to put back into the community. You
24 know, I have seen recent reports about the Metropolitan
25 Police, for instance, that they should be broken up.

1 Yeah, why not? Let's start again. We need a police
2 service and not a police force. We need reform. We
3 need independence. We need scrutiny and honesty and
4 integrity. And everybody has that they have just been
5 unwilling to do that. Black people are still enslaved.
6 This is modern day lynching. This is colonialism in a
7 modern day. And we have never received reparations and
8 it's now time to repair that damage because it's -- it's
9 just ongoing trauma to the communities that they serve.
10 Q. How can that damage be repaired?
11 A. I don't think the damage itself can be repaired but we
12 need to do it for the future. The future generations,
13 that's how it can be done. That's why I do the work
14 that I do. So for Sean or perhaps Sheku, we can't do
15 anything now but we need to do it for Sheku's sons and
16 for Sean's sons. Yeah.
17 Q. Thank you. Can you bear with me just one moment,
18 please?
19 A. Thank you.
20 Q. Thank you, Ms Rigg, I have no further questions.
21 LORD BRACADALE: Are there any rule 9 applications? No.
22 Well, Ms Rigg, that completes your evidence and thank
23 you very much for coming to give evidence to the Inquiry
24 and tell us about your family's experience and your
25 thoughts. I'm very grateful indeed for that. In a

1 moment the Inquiry will adjourn and then you will be
2 free to go.
3 The Inquiry has now come to the end of this hearing.
4 The Inquiry is scheduled to have another evidential
5 hearing on 24th September 2024 and meantime, the Inquiry
6 will adjourn.
7 A. Is it possible if I could just say something to
8 the Chair, please?
9 LORD BRACADALE: Yes, by all means, yes.
10 A. Thank you very much for inviting me to be a family's
11 voice to speak at this very unique and very important
12 inquiry. I hope it achieves what it has set out to do.
13 Thank you very much.
14 LORD BRACADALE: Thank you very much for these thoughts.
15 (2.48 pm)
16 (The hearing was adjourned to 24th September 2024)
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