The Sheku Bayoh Public Inquiry

Expert Witness Statement

Deborah Coles

Taken by [redacted] via Microsoft Teams
on 25 and 30 April 2024

Witness details

1. My full name is Deborah Coles. My date of birth is in 1962. My contact details are known to the Inquiry.

2. I previously provided a statement to the Inquiry in September 2023. This is SBPI-00366.

Involvement with and support for Sheku Bayoh's family

3. I am told that Lindsey Miller in her Inquiry statement SBPI-00428 paragraphs 25 and 23 mentions three meetings between the Crown Office and Aamer Anwar at which I was present in July 2015, 15 October 2015 and October 2018. I am asked if I remember these meetings.
4. I remember a meeting in Aamer Anwar's office quite early on, I'm not sure of the exact date. I recall raising the question of Article 2 of the European Convention on Human Rights and, in particular, the importance of a robust,

independent investigation that ensured proper meaningful engagement of his family. I also reiterated the importance of properly considering the circumstances of Sheku Bayoh's death, but also the broader context in which it occurred. I mentioned the fact that INQUEST has evidenced a pattern of restraint-related deaths of Black men that generated significant public and parliamentary disquiet and resulted in highly critical inquest conclusions and coroners recommendations. I therefore stressed that the question of restraint and race was, in our view, very significant.

5. I am asked what the relevance of Article 2 right to life is to an investigation following a death such as Sheku Bayoh's. Article 2, the right to life, has transformed the investigation of deaths in custody. It creates the procedural duty to conduct a thorough, independent and effective investigation and one in which the bereaved family are given access – in other words, the opportunity to play a meaningful part in it. This has created a set of minimum standards by which investigations (including inquests and Fatal Accident Inquiries) are conducted. The investigation must be capable of establishing the cause of death, identifying those responsible and holding them to account. There is also the positive obligation to protect life and so when a death occurs after the use of force by state agents, in this case police officers, the investigation must look not only at individual actions but at the broader systemic issues.

6. The key role of INQUEST's specialist casework with bereaved families and their lawyers is to empower and support them to take up those rights to play a central role in the investigation process that follows a custodial death. This is not just about them being treated with dignity and respect but facilitating their meaningful and effective involvement in the process. This is in the family interest and the interest of the investigation which can benefit from the family's insight and explore their concerns.

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7. Properly conducted inquests which expose the truth, culminate in a finding about what went wrong and make recommendations for change that can help families in their bereavement process. They can be vital to public understanding, and public lessons learning in ensuring accountability. They also act as a checks and balance on the independent investigation framework. Many investigations have been exposed as inadequate and conclusions about the causes and circumstances of the death rejected by inquest juries.

8. This judicial pronouncement after a legal challenge following the racist murder of a young Asian prisoner articulates the voice of families as well as the law:

"*The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of wrongdoing (if justified) is allayed; that dangerous practices and procedures are rectified;* ***and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others"***[1]

9. . This was the human rights context in which I was approaching the meetings I attended. I was told that I should be reassured that they were taking advice from the Independent Police Complaints Commission ("the IPCC"), as it was then. I did not take confidence from that, in part because of our concerns about the way in which the IPCC had conducted a number of investigations into deaths in similar circumstances, albeit that we had an ongoing dialogue with the IPCC and we were raising our concerns about these deaths and, in particular, the dangers of restraint and the disproportionately we had seen in relation to deaths of Black and racialised people.

[1] House of Lords - Regina v. Secretary of State for the Home Department (Respondent) ex parte Amin (FC) (Appellant) (parliament.uk)

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10. I was slightly concerned by the fact that that was mentioned to me as if that should provide confidence at a time when I know that my discussions with Aamer Anwar and with the family of Mr Bayoh have revealed some real concerns about the immediate steps that were taken post-Sheku's death: the treatment of the family and their friends, the lack of independence from Police Scotland and the PIRC, but also, I can't recall at which meeting this was, but there was certainly a discussion about the instruction of the pathologist, Steven Karch who was a proponent of the widely discredited term 'Excited Delirium'. We had seen over a pattern of deaths that INQUEST had worked on how Excited Delirium, a pseudoscientific and highly imprecise, highly racialised term, was being used and put forward at inquests as a way of erasing or excluding the significance of restraint on the cause of deaths and exculpating the conduct of officers whose dangerous use of restraint may have significantly contributed to the death. We have also seen how it is infused with racial stereotyping and associated with terms like "superhuman strength" and "impervious to pain". In these cases, forcible restraint by police officers had immediately preceded the fatal collapse and the contribution of restraint was highly contested. So the very fact that he had been instructed caused me significant concerns which I spoke about at that meeting.

11. My concerns around some of the work I had done in relation to Sheku Bayoh with Aamer Anwar and his family was that I was worried that the importance of an independent investigation with the effective participation of bereaved people and an investigation that was held in public to properly explore the full circumstances of the death were unlikely, in my view, to be met by the PIRC and by what was then going to be a Fatal Accident Inquiry ("FAI"). They were already talking about the fact that this would be a PIRC investigation and then an FAI. That was in and of itself making assumptions about the fact that they weren't investigating potential criminality or wrongdoing on behalf of the officers. Investigators should not assume at the outset of an investigation that officers might not face a criminal prosecution further down the line, so that was a matter of concern. In regard to Steven Karch, I think the response I

recall to my concerns was at the time was, "the IPCC instruct him,". We know from our casework that he was a controversial figure who INQUEST lawyers would never consider instructing. It's been the work of pathologists like Nathaniel Cary and psychiatrist Maurice Lipsedge, who we recommended to Aamer Anwar, that should be instructed. Cary and Lipsedge have been really important in challenging proponents of Excited Delirium. They have drawn attention to the dangers of restraint techniques, in particular prolonged and prone restraint, the physiological impact of restraint and the struggle against it, and the multi factorial nature of these deaths.

12. I am asked to summarise my concerns with the IPCC at the time. Broadly speaking my concerns relate to: not investigating the death as potential wrongdoing or criminality; delays in interviewing police officers; lack of independence of experts; instruction of pathologists and experts without sufficient expertise, particularly in restraint; delays in investigation; the failure to investigate race or racism as possibly having a role to play in the death; and then the lack of effective involvement of bereaved people and their legal rights in the process.

13. I am asked whether I remember discussing the limitations of FAIs at the meetings with COPFS. Yes. By that time, I had become aware of how such deaths were being investigated in Scotland. In the absence of criminal prosecutions which are extremely rare it is the inquest and FAI to which families turn for answers. I know of direct comparable deaths that I could look to in terms of the importance of the inquest which in the England and Wales jurisdiction, is held in public with a jury with families legally represented through access to non means tested public funding. I know this from our casework because so many of these deaths were contentious with a broad examination of all of the issues and importantly, some very important jury conclusions and coroners' recommendations, particularly about the dangers of restraint. So, it was a concern to me to find out about not only the serious delays in the FAI process, but the serious limitations in terms of scope, family

engagement and experience. One of the shared concerns across jurisdictions is the expertise of those who are carrying out the inquest or FAI into restraint related deaths, knowing and understanding the complexity of issues and the evidence that should be called to ensure a full and fearless inquiry. By the time of Sheku's death there were many detailed research reports and guidance on the dangers of restraint in part because of the high-profile nature of some of these deaths.

14. I am asked if I remember the three specific meetings mentioned by Lindsey Miller. There doesn't seem to be a record of those meetings. I know there was the meeting I attended with Frank Mulholland when he was Lord Advocate. I thought that that was an extremely productive and positive meeting. I distinctly remember being surprised and really welcoming the openness and seriousness with which the Lord Advocate listened to what we all had to say. I had the opportunity to talk about my experience of similar deaths in England and Wales and was listened to really carefully. At that time there were already real concerns about the way in which the investigation was being carried out. My recollection is that there was a commitment from him to ensure that this was a very far-reaching inquiry. The very fact that we had an audience with the Lord Advocate at such an early stage, to me, gave me quite a lot of confidence and made me feel quite reassured that somebody of such legal seniority was taking on what we all had to say with seriousness. The very fact that he met with the family, that was extremely important and good practice.

15. I'm asked if I have any further comments to make about the meetings I attended with the Crown Office or Lords Advocate. Much later down the line, on 23 October 2018 my notes say, I was at a follow-up meeting with the next Lord Advocate, James Wolffe, and the family and their lawyers. My role in these meetings would always be to listen, but also to add my thoughts where I felt I had something useful to say. It was my expertise and understanding of investigations into these deaths over three decades that added value to

those meetings because I could compare my experience of similar deaths, and how investigations were carried out to encourage best practice and to try to avoid a repeat of investigations I have been involved in that have gone wrong. There was enough good practice to be able to help inform the approach that the relevant authorities were taking. As the meetings went along, it was becoming increasingly clear that this was not going to be the robust independent investigation that we had hoped for and was committed to following the meeting with the previous Lord Advocate Frank Mulholland.

16. I am asked how this was becoming clear. It was becoming clear from my work alongside Aamer Anwar with the family, and then the discussions that were coming out of the meetings. There was a lot of defensiveness from the PIRC and Crown Office in response to legitimate concerns being raised. Without meaning to be disrespectful, it felt quite shambolic and rather inexperienced, in the sense of not taking on board some of the concerns that were being raised. It didn't feel that it was an investigation that was being lead to uncover the truth. It felt more like an investigation that was trying to deny the concerns that the families and their lawyers were raising about the circumstances in which Sheku died. That was also not assisted by the role of the Police Federation and the misinformation that was appearing in the media. I thought it was absolutely reprehensible that the pathologist who had been instructed (Karch) then did an interview with a newspaper about alleged drug use. I believed this to be such unprofessional behaviour from somebody who is supposed to be an independent expert, and a clear attempt to create a narrative about the death that excluded restraint. There appeared to be press briefings of selective material designed to demonise Sheku out into the public domain relating to information about alleged drug use. This is a familiar pattern we have seen over decades, wherein the State orchestrates narratives centring on the supposed criminality and violence of the deceased. In this case, the expert was implying drugs were the primary issue in Sheku's death. It was also interesting to note that the Police Federation drew attention to deaths in England and Wales where an inquest or coroner made

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

17. I am asked what made me think that the investigation was trying to deny the concerns that the families and their lawyers were raising about the circumstances in which Sheku died. It was because of the way in which the family and, particularly, Sheku's partner were treated right from the outset. It was appalling that a grieving family, who'd found out about their loved one's death in the most awful circumstances, were themselves treated as potential suspects. But it's also about the approach and attitude and the culture of those who are conducting what should be a full and fearless independent investigation. I felt really concerned about the initial damage that had been done; not only does that undermine trust and confidence of the family in the processes that follow, but, of course, we were not really being given any reassurances that the concerns raised were being taken onboard. For me, there was an attempt by the PIRC and Police Federation to present the police as peripheral to what happened rather than recognising that had it not been for the police encounter with Sheku, he would still be alive. That was the central issue. It seemed there was a calculated attempt to try and explain away the police involvement in Sheku's death, and that was done from a very early stage and then it was a constant feature. The concentration was on the purported violence of Sheku rather than an understanding that resistance to restraint is often borne out of fear and an attempt to breathe.

18. . The only other thing I would say is that what are known as the "golden hours" are absolutely critical and it was quite a long time before the PIRC took control of the investigation. Police Scotland had control of the scene and of managing the information that went out to Police Scotland's senior management, but also to individual officers and their opportunity to confer with each other, and also in terms of the treatment of the family. So, there is

a concern about how quickly an independent investigation body should be taking control of and managing everything from a very early stage. It almost felt like it was quite difficult for the PIRC because they did not have previous experience of investigating such a death.

19. I am told that the Inquiry has heard evidence of allegations that police officers carried out checks on police computer systems using the names of the family and friends of Sheku Bayoh, and also their lawyer. I am asked whether I was aware of that at the time, and whether I have any comment to make. I was not aware of this although I am not surprised given the resistance of the police to scrutiny, the culture of denial and defensiveness operating, and the fact Aamer Anwar and the family were speaking out and trying to do their best to ensure the effectiveness of the investigation. Unfortunately, it is families and their lawyers who often have to be the driving force of investigations especially where they start in a way that undermines trust and confidence which was the case here. Sadly, the experience of families feeling like potential suspects is not unfamiliar following contested police related deaths and as we know for the Undercover Policing public inquiry there is a disturbing history of bereaved families being under surveillance and family justice campaigns being spied upon.

Experience from prior cases

20. I am shown my previous statement in which I spoke about the delivery of the death message to families[2], the relationship between families and FLOs[3], the handling of Post Mortems[4] and media engagement where misinformation has ended up in the public domain[5]. I am asked whether I have any further examples of the issues I raised there as they have come up in previous cases.

[2] SBPI-00366 pages 10-14
[3] SBPI-00366 pages 15-20
[4] SBPI-00366 pages 21-24
[5] SBPI-00366 pages 25-28

21. Oladeji Omishore was a Black man who was tasered on a bridge while in a mental health crisis. In order to get away he climbed over a wall and went into the river and subsequently drowned. The first his family knew about the fact that there was any police involvement was when they arrived at the hospital. It was the medical staff who actually informed them that he'd been in contact with the police. To make matters even more shocking, one of his sisters who lives in America had seen footage that had appeared on social media and had initially thought "here's another Black man who's been subject to the use of force by police", not realising that in fact it was her brother. They then saw the misleading information put into the public domain by the Metropolitan Police, implying that Oladeji was carrying a screwdriver when in fact it was a cigarette lighter[6].

22. For me that was just so reminiscent of all the poor practices from the past where there is an early attempt to shape the narrative and public understanding of what happened, demonise the person who has died but also results in racial stereotypes equating Black men with dangerousness and implications of the alleged violence of the individual concerned. Once that enters into public consciousness, it's actually quite difficult to challenge.

23. It's so important that there is good practice. The worst thing imaginable has happened to a family, and you should not have legal processes that further traumatise and further damage people who are already trying to deal with the unimaginable. You're talking about empathy; you're talking about just treating people with some humanity. This is something that should be in training for people who engage in this kind of work in a professional capacity: understanding traumatic bereavement and how - where somebody dies following a police encounter or following the police use of force - you immediately are thrown into a completely unknown arena where the police,

[6] London man who died after being shot with Taser was holding firelighter | Police | The Guardian

the state, have control of absolutely everything. They have the information, they have the resources, they have the CCTV, or body worn camera footage. You are completely reliant on others for information about what's happened. But then you are then also experiencing the post-death investigation processes and formal legal processes. You also have to understand the way in which families' grief is compounded when they see the dehumanisation and demonisation of their loved one.

24. The Roger Sylvester case -- that's going back over 20 years, but in that case the initial pathologist gave a kind of impromptu press briefing that alleged that Roger had taken, or was a user of, crack cocaine. There was absolutely no evidence to support that, and yet that was picked up by the media. Then you have that narrative, that demonisation, and that real attempt to shift attention away from the contribution of the restraint to his death, which was subsequently ruled as an unlawful killing – the jury finding he had been restrained for too long in the wrong position (prone restraint) and was not given proper medical attention. This was then challenged by police officers. Unfortunately, we've also seen that with Sheku Bayoh, the attempt by those with a particular interest in deflecting away from police officers' involvement by reference to allegations around drug use.

25. Not only do the police demonise the individuals who died, but there's also the blaming and vilifying of families or communities. This includes attempts to characterise communities or families as being difficult or angry for the simple reason that they're rightly asking questions insisting on accountability, and sometimes engaging in some campaigning. I am also aware of this through the Undercover Policing Inquiry as some of the families, their campaign groups and their lawyers were spied on after deaths in custody. If they don't just go for the families, then they'll also try and go for their lawyers. Reflecting on my involvement with Sheku, I worked very closely with the family and Aamer, particularly in the early stages. Aamer contacted me because he knew of our work on deaths in custody, particularly on restraint-

related deaths of Black people. He sought advice from me because of my expertise. Aamer's role was to properly represent the family, and so, raise important questions to those responsible for the investigation. The central issue that we discussed very early on was the question of race. I also raised concerns about previous cases we had worked on and how the question of Excited Delirium often came up and the need to be prepared for this and ensure the importance of a pathologist with sufficient expertise in the arena of restraint. That was something that I talked with to Aamer about right from the outset, and how excited delirium plays into those racial stereotypes to deflect away from police brutality or police use of restraint.

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

In relation to lawyers advising whether or not to raise issues of race on behalf of a family, I am asked whether it can be a positive or a negative to bring up the issue at early stages of an investigation. The issue of Black people dying disproportionately following police use of force is a long-standing thematic area in our work, and even before there was any monitoring of race or ethnicity of those who died, we, in our casework, saw that there was a systemic pattern.

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27. We recently produced an evidence-based report called *I Can't Breathe*[7]. On paper, England and Wales have a highly developed system of oversight of police conduct, with provision for identifying racism and a well-established investigation and coronial system to examine the circumstances of deaths in state custody, for the state to be accountable. However, we were aware that the lethal pattern of disproportionality continues and that no death of a Black person following police custody or contact has led to officers being effectively disciplined for racism or held to account. This was also despite the recommendation in the Angiolini review that the police watchdog investigators "should consider if discriminatory attitudes have played a part in all cases where restraint, ethnicity and metal health play a part. One of the things that we had documented in our work was how race was the elephant in the room. It was invisibilised, erased from the official narratives about the death because it was never investigated as part of the investigations that followed the deaths or through the Inquest hearing.

28. We got some funding to examine this area in more detail, and an analysis of our casework and statistical data. Any report needed to have families at it centre and so we spoke to six family members of five Black men who had died after lethal use of restraint. The question of whether racism had contributed to the treatment of a loved one was invariably in the minds of Black families, but not one that most felt that they could actually raise. Their reluctance to raise race with the IOPC or in their public statements was because they feared being seen to 'play the race card' and provoke additional hostility in a process that they experienced from the outset as being hostile and adversarial: particularly, where they'd seen attempts to speak ill of their loved one, or seen misinformation coming out. In the aftermath of the deaths, families described the attempts to deflect or minimise the involvement of police and possible wrongdoing by demonising their loved ones and drawing on those racist stereotypes of Black men, that

[7] SBPI-00513 – I Can't Breathe: Race, Death and British Policing: INQUEST (20 February 2023) https://www.inquest.org.uk/i-cant-breathe-race-death-british-policing

vilified them. So, they felt that if they were going to raise this as an issue, it would be construed as being acrimonious or used against them, and hinder or frustrate their prospects of unearthing the truth. Raising the issue of race families said could elicit accusations of "having a chip on your shoulder", being "militant,", seen as an angry Black family"[8].

29. We also interviewed lawyers that we work with who are human rights lawyers and, in particular, had an understanding of the Equality Act 2010. We interviewed 12 expert lawyers with experience of cases involving the deaths of Black people following the use of force. The aim was to identify what prevents robust investigation of the role race plays and to gather clear ideas about what needs to change and how that might be achieved.

30. There were a number of issues they raised. One is that the police at the rank-and-file level are often uncooperative when questioned and deny that their actions were influenced by racism. Their superiors invariably back their officers, which means that no proper investigation can take place by the IOPC, which itself appears to lack courage to force officers to cooperate. I would also suggest that there is a lack of proper understanding on the part of the investigators about what racism actually is and how, in the absence of very clear racist language, you're looking at racist tropes, you're looking at the impact of racial stereotyping, but you're also looking at the fact that racism is structural and institutional. As one lawyer said: "I have yet to see a case where the IOPC have conducted a proper investigation into race: looking at stereotypes, past evidence; potential racist thinking; asking the right questions; getting expert evidence from a race advisor. I have never seen any of that'. "Race looms large in restraint related deaths, but it is never spelled out [in the IOPC investigation]".

[8] SBPI-00513 'I Can't Breathe' report p.63.

31. In terms of challenging and asking questions about race, I think that a lot of investigators don't have a proper understanding about how to approach this issue. In the `Silvia Casale review[9], which was the reinvestigation into the death of Sean Rigg. At p.70 under the heading "the issue of race" she looked at some of the questioning of officers and drew out some of the language that had been used by some of the police officers. It was about the way Sean was behaving, and an officer had said, "*obviously the behaviour…is unusual but then whether that's mental health or other reasons which could have been, especially with people you come across in Brixton…*". Brixton has got a high Black population. She said that would have been the obvious place where you start asking what that means. "*It may be that [the officer] had some reason other than race in mind, but the question was never asked."*[10] The Casale review concluded that the IPCC should have addressed the issue of race adding that the *"lack of reference to race throughout it is not a sign of non-discrimination but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately."*

32. One of the other challenges with the way in which the IPCC/IOPC have looked at these issues, is it's been very much a tick-box exercise. It doesn't look for patterns of actions and conduct to evidence racism and discrimination, and only really looks at if there is overt discriminatory language, which isn't always apparent in the evidence. That broader systemic problem of attitudes and assumptions that then inform the way in which the police treat somebody, very rarely is that the focus of questioning.

33. The lawyers suggested that the guidance from the IOPC for its investigators in cases where there may well be evidence of unlawful discrimination should be more explicit to put the onus on the police to offer reasons other than racism to explain their actions. One of the problems is that the IOPC as an

[9] [redacted] Report of the independent external review of the IPCC investigation into the death of Sean Rigg (Casale Review) (2013)
[10] P.71

institution has not publicly accepted that institutional racism exists. That, in my view presents a challenge in regard to the culture and mindset. The fruits of the investigation are then what will go towards evidence to be heard at an inquest in the absence of a prosecution, which is obviously very rare. If you're not investigating that at the outset, you've got a situation where it's very unlikely that a coroner will include race within the scope and remit of the Inquest. In the Seni Lewis case, there was an attempt to include race and the coroner refused, yet the coroner herself recognised during the inquest that race was "the elephant in the room".

34. The UN in response to their inquiry on law enforcement and people of African descent[11], they make a very clear recommendation that race needs to be part of any investigation:

"States must take firm and prompt action towards accountability and redress in all cases and to guarantee non-repetition. This includes strengthening independent oversight mechanisms and examining the role that racial discrimination, stereotypes and biases may play in law enforcement and accountability processes. The High Commissioner reiterates the recommendation to reimagine policing and the criminal justice system with the participation of Africans and people of African descent. Rebuilding trust in these institutions is essential in order to ensure that they protect and serve all members of society without discrimination."

35. For the *I Can't Breathe* report we researched the issue and found that none of the post-death investigation processes; the IOPC; the coroner's inquest; prevention of future death reports; the Crown Prosecution Service; meaningfully consider the potential role of racism. We looked at 12 cases of Black men that had occurred between 2008 and 2018. We looked at the record of Inquest which sets out the findings and conclusions and not a single

[11] https://documents.un.org/doc/undoc/gen/g23/139/91/pdf/g2313991.pdf?token=HxSmfh1WdqYR3sZYvl&fe=true paragraph 64

record or report mentioned racial discrimination or racism. Only two of the Cause of Inquest and one Prevention of Future Death report had the ethnicity of the Black men who died at all. The result is that the potential role race may have had is entirely absent from the official version of these events.

36. That renders race and racism invisible. If you don't acknowledge something as a problem, as an issue, how can you develop policy interventions, and how can you ensure that the issue is addressed. Then, of course, it's often at odds with how the bereaved family, and increasingly the wider public, understand the broader context of the death and I think that is that is absolutely fundamental.

37. Having painfully witnessed the decades of deaths and impunity for human rights violations we have addressed the need to rethink policing as currently practiced in the UK and decreasing the reliance on policing in the UK. For example, the approach to people in distress, or in mental health crisis and recognising this as a public health issue warranting a response where the default is not to the use of force but de-escalation, care and compassion and access to non-punitive medical care where appropriate. To this end we have recommended an end to the use of police as first responders to people in mental health crisis.

38. The other recommendations in the *I Can't Breathe* report are as follows:

Post-death investigations and scrutiny

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

b. The IOPC should amend their guidelines and practice for handling investigations into racial discrimination to bring them into line with the way allegations of racial discrimination are approached in civil courts. This means explicitly incorporating a shifting burden of proof set out in the Equality Act 2010 and ensuring this guidance is properly applied through specific training of IOPC investigators.
c. The Chief Coroner should develop detailed guidance and training on how coroners should approach investigating racial discrimination in inquests to fully reflect Article 2 and the Equality Act.
d. In the context of Scotland these recommendations and the findings of this report more broadly should be considered by the Police Investigations and Review Commissioner, the Crown Office, and in Fatal Accident Inquiry processes.

Inspectorate and monitoring bodies

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

The treatment of Black people by the police

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

Restraint

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

Mental Health

h. In the short term, where police do become involved in responding to a mental health crisis through absolute necessity, national policy and practice must ensure that de-escalation and care is the focus. Every effort must be made to avoid use of force and restraint, and minimise police contact.

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

Data

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

Duty of Candour

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

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

Access to Justice

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

National Oversight Mechanism

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

Transformative Social Change

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

Experience and comparisons between England and Wales, and Scotland

39. I am shown paragraph 15 of my previous statement to the Inquiry[12] in which I mention doing some scoping work on the investigation of deaths in custody and detention in Scotland. I am asked for more detail about that work, what it covered and whether any relevant points came out of the work. The scoping work was started because I had become involved in a number of individual

[12] SBPI-00366

deaths taking place in Scotland including: Sheku Bayoh, Katie Allan and William Lindsay, Alan Marshall and a young man of mixed heritage who died in a mental health setting.

40. I'd also been invited by the Scottish Government in 2018 to give evidence as part of some work they were doing, the Review of the arrangements for investigating the deaths of patients being treated for mental disorder ('the Section 37 Review')[13]. I had a meeting with Scottish Government and the review team, and then also did some associated work with the Mental Welfare Commission who were also looking at how they investigated deaths in mental health settings.

41. Because my expertise was very much based in England and Wales, I was really interested in how deaths in custody and detention in Scotland were investigated and so started doing a piece of scoping work. It was getting an understanding, through involvement in individual deaths and working with the lawyers involved; and getting an overview of how deaths were investigated. As a consequence of some of that learning, I became aware that the only pre-Fatal Accident Inquiry independent investigations that were being carried out was in the context of policing. Because of the death of Sheku Bayoh, I've become concerned about the role and expertise of the PIRC, but I was also really surprised to learn that in the context of prison deaths that there was no independent investigation body that examined prison deaths. I had a number of meetings with various people involved, including the National Preventative Mechanisms Scotland (that's made up of the inspection and monitoring bodies that look or have an interest in custodial or places of detention). I met with HM Inspectorate of Constabulary in Scotland HMICS to try and get an understanding of deaths in police custody.

[13] WIT-00084 - Review of the arrangements for investigating the deaths of patients being treated for mental disorder: Scottish Government (December 2018) https://www.gov.scot/binaries/content/documents/govscot/publications/progress-report/2018/12/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/documents/00544242-pdf/00544242-pdf/govscot%3Adocument/00544242.pdf

42. I became very aware of the difficulty in finding out information about who was dying, where they were dying, the lack of any proper disaggregated data on race, ethnicity, or on issues around gender. I was quite shocked by the difficulty in finding this. I became aware through Linda Allan, the mother of Katie Allan who died in Polmont Young Offenders Institute, of some work that she'd been doing with the Scottish Centre for Crime and Justice Research ('SCCRJ') led by the academic Sarah Armstong and colleagues[14]. I have since met up regularly with academics who have shone a light on the FAI system and conducted research on determinations, trends and patterns and also tried to get data who is dying.

43. Many years ago, when we were trying to argue for greater and more meaningful conclusions from inquests in England and Wales, I had used the example of Fatal Accident Inquiry determinations as good practice. I saw that they had a broad overview of the circumstances in which somebody had died. This contrasted with the conclusion of inquests which, at that time, were very often short form verdicts. There was nowhere other than press reports, if they were written, to get an overview of the circumstances of which somebody had died following an inquest.

44. I saw the determinations and the way in which they were written and made public as something very positive and important,

45. Through the scoping work and meetings with the SCCRJ, I became aware of the serious limitations of the FAI process They have done a series of significant reports and this research has been vital in shining a light on the FAI system and prison deaths. In the absence of an independent investigation body, the Fatal Accident Inquiries are the only public forum in which prison deaths are scrutinised. This research makes clear it is failing

[14] SCCJR - The Scottish Centre for Crime & Justice Research.

bereaved people and the public interest in not performing that role effectively, it is subject to serious and unacceptable delay, families are rarely legally represented and there are rarely recommendations made by Shefriifs in relation to addressing systemic or individual failure. I found this particularly concerning and in contrast to the growing practice very much in contrast with a welcome trend of inquest juries and coroners reaching critical conclusions outlining failures in policy and practices and drawing attention to preventative action needed to stop future deaths. And coroners recognising the important preventative potential of these inquiries to satisfy the Article 2 function. The *Amin, R (on the application of) v. Secretary of State for the Home Department* [2003] UKHL 51 (16 October 2003)[15] judgment on Article 2, and what an Article 2 investigation should do is a really powerful description of how important it is to have an investigation, to have an inquiry that can deliver the truth but also, so that families can think that there can be some positive change from what is often a protracted and complex legal process.

46. In my experience, all the families that INQUEST have ever worked with, will tell you that they want answers. They want the truth. They want an acknowledgement of failings if there have been some, they want an apology. But more than anything, they want the process to lead to change. They want it to stop somebody else dying in similar circumstance. Therefore, it was really concerning to me that the FAI process in Scotland appears to be not recognising the importance of making recommendations, not just in the interest of the individual state institution or state body, but in the interest of learning across places of detention. My conversations have been largely focused on trying to understand some of these challenges.

47. An issue that we struggled with and continue to do so is delays in coroner's inquest. It became really clear to me that there were serious systemic problems with the FAI process in terms of delays. Also seeing the research

[15] House of Lords - Regina v. Secretary of State for the Home Department (Respondent) ex parte Amin (FC) (Appellant) (parliament.uk)

that the academics had done on the rare occasions in which sheriff's determinations made any recommendations was a real concern to me.

48. One of the real concerns I have is the fact that there is no similar organisation to INQUEST operating in Scotland, so there is an absolute gap in terms of independent advice and support to people who have had a death in custody or detention. Both Linda Allan and another family member of a man of mixed heritage who died in a mental health setting I met just the last time I was up in Scotland, said to me that the importance of me explaining the processes and putting him in touch with a lawyer has made such a difference to him and his family's ability to cope with the trauma of what's gone on, but that it shouldn't be a matter of luck that somebody happened to tell him about INQUEST.

49. In Scotland there remain real challenges around funding, around people finding out about their rights and about their ability to effectively participate in these processes, and delay. If you're not involved in the investigations prior to a Fatal Accident Inquiry, in effect, you are isolated and alone with the trauma of what's happened to you for years. Most families will tell us that you can't begin to properly grieve until you found out what happened and why it happened, and so I do think that it feels to me that there's an absolute need for a fundamental review and overhaul of these processes, and form the people I have met involved in oversight and monitoring bodies and others I actually think there's a real appetite for this.

50. I am asked whether I intend to produce something at the end of my scoping work in Scotland. Yes. I hope to produce a short briefing on some of our findings, but also some recommendations for the next stage. I'm very much hoping that we can get some funding to continue this and take it to the next level. Do some proper work with families about what does best practice look like, what would they like to see. If you're trying to design a new system or improve a system, it's the voices and experiences of families that are most

helpful in in doing that work. That's the next stage of this project, then working with the Scottish Government to see whether or not there's an interest in taking forward some of this work.

51. I'm asked about the cases I've mentioned from Scotland: Katie Allan, William Lindsay, Sheku Bayoh, whether these are the main ones in Scotland that I have experience with. Yes. I've observed and met with the family of Allan Marshall as well, which was a very concerning death in prison.

52. I'm asked, from what I've seen in Scotland and my experience in England and Wales, whether I think learning and recommendations from cases in England and Wales translates across to Scotland. Yes, whilst acknowledging that there is a difference because of the FAI process. But there's just so much learning that could be translated.

53. I'm asked whether I have anything else to add in particular about comparisons between England and Wales, and Scotland. I've seen the real importance of wide-ranging inquests that have been held into deaths in England and Wales. Very significant jury findings and coroner's recommendations that have actually impacted on changes, significant changes to policy or practice, or have made the government recognise that more independent scrutiny is needed.

54. In the context of deaths of Black people following restraint, a number of high-profile deaths, led to the commissioning of the independent review, by the then Prime Minister Theresa May which Lady Elish Angiolini led and I was appointed as her special advisor. This was the first ever review of deaths in police custody and following police contact and was a broad review which heard form a range of stakeholder including bereaved people. Concerns around a pattern of deaths, particularly in Styal Prison in the northwest of England led to the setting up of Baroness Corston's review of women in prison. Then, there was the disquiet around deaths of children and young

people in prison which led to the Westminster government setting up the review chaired by Lord Harris into deaths of children and young people.

55. Those three reviews were triggered by disquiet about the circumstances of deaths of particular people, but as part of the review, they were an opportunity to look at issues around the treatments of families, the investigation process, the accountability mechanisms, the mechanisms for learning. In all three reviews INQUEST was commissioned to hold Family Listening days so those involved could hear directly from bereaved people about their experiences and their recommendations for what needed to change across the post death processes including the role of oversight bodies.

56. When I was looking at the Scottish jurisdiction, the issue of deaths in custody and detention, and the treatment of bereaved people and learning and accountability has not been the focus of as much political parliamentary attention as it has been down south. It's only more recently, driven by the families, lawyers and some academics, that this is started to get taken on board in a more meaningful way.

Collection of Data

57. I refer the Inquiry to three submissions INQUEST has made to the UN on data in deaths in custody.
    a. INQUEST submission to the United Nations High Commissioner for Human Rights report on Systemic Racism (December 2020)[16]
    b. INQUEST submission to the United Nations International Independent Expert Mechanism to Advance Racial Justice and Equality in the

[16] WIT-00087 Submission to the United Nations High Commissioner for Human Rights report on Systemic Racism: INQUEST (December 2020) https://www.ohchr.org/sites/default/files/Documents/Issues/Racism/RES_43_1/NGOsAndOthers/INQUEST.pdf

context of Law Enforcement on policing data disaggregated by race and ethnic origin (May 2022)[17]

c. INQUEST submission to the United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions on the investigation, documentation and prevention of deaths in custody in the criminal justice context (March 2023)[18]

58. Despite recommendations made in the Angiolini review into deaths and serious incidents in police custody[19], there is still no public data set showing the breakdown of all deaths following police restraint disaggregated by race and ethnicity. For me, that begs really important questions about trying to understand how race and racism impacts on these deaths.

59. A problem INQUEST have identified in relation to the collection and publication of data on deaths in custody is that the way official figures on deaths in police custody or following police contact are published obscures the level of racial disproportionality. The definition of custody used by the IOPC means that very similar cases where a person was in direct contact with the police prior to their death, but had not officially been arrested or detained are excluded from their overall custody data. They're put in a broader 'other' category. The in-custody deaths tend to refer to the self-inflicted death, or the death of somebody who's actually physically inside the police station, whereas some of the deaths that we're particularly concerned about tend to happen in the street. They would go within the category of

[17] SBPI-00510 Submission to the United Nations International Independent Expert Mechanism to Advance Racial Justice and Equality in the Context of Law Enforcement on Policing Data Disaggregated by Race or Ethnic Origin, INQUEST (May 2022) https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=1939ebb6-78e0-429a-9943-9db7f03cb319

[18] WIT-00086 - Submission to the United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions on the investigation, documentation and prevention of deaths in custody in the criminal justice context: INQUEST (March 2023) https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bbd81fac-7136-4963-ae53-a7ae7d54b529

[19] SBPI-00496 – Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC (January 2017)

'following police contact'. It's an ongoing issue that we raise with the IOPC repeatedly. There are also people who are not officially arrested or detained but have died during their police encounter. Those deaths are excluded from that overall custody data. So the result is that deaths, such as those involving use of force and restraint, are lost in the broad other category. When there's a parliamentary question, the Home Office uses only the custody category to count how many deaths occurred by ethnicity, and they constantly claim the numbers are not unusual when looking at long-term trends.

60. The *I can't Breathe* report, explains all this in more detail in Part 3 "Evidencing racial disproportionality". We were concerned that that deaths of Black people in particular were disproportionate when you look at the population and were some of the most violent, neglectful and contentious. We were seeing it in our casework and wanted to analyse this in more detail. So we obtained data through freedom of information requests and through requests to the IOPC. What we were able to demonstrate was from 2012/13 to 2020/21, there'd been 119 deaths involving restraint recorded by the IOPC in, or following, police custody or recorded as other deaths following police contact. Of these, 23 were Black people, 86 were white, 5 were Asian, and 4 were mixed race. What our data then showed was that Black people were seven times more likely to die than white people following the use of restraint in police custody or following police contact.

61. I don't think it should have been down to an NGO to have made public information that the IOPC clearly had. I would say that it's absolutely vital that the Scottish government commit to making information on deaths, race, ethnicity, and other protected characteristics readily available.

62. Most important of all is that if you properly begin to understand the reasons behind why people are dying, you can then develop policy practice and change to try and stop deaths happening in the future. If you invisibilise and

hide an issue, then that makes it very difficult. It should not be incumbent on bereaved families to demand that transparency.

63. Going back a couple of years, after Sheku died, I had a very positive meeting with someone who was at the HMIC. Her role was inspecting police stations and we had a conversation about problems with data. I was asking about numbers of deaths in police custody; issues around restraint; self-harm; when they were doing inspections, how were they informed if other deaths had happened and the learning that came out of that. She effectively acknowledged that there was a real disconnect between the inspection role and what learning and information they could take from any of the investigations into deaths - be that deaths of people arrested for drunkenness, or any suicides or, at worst, the restraint deaths. It was exactly the same down South. I felt, and still feel, that there is some real potential for improving, in developing the systems within the Scottish jurisdiction.

64. I am asked whether the data is more easily available in England and Wales than in Scotland. Yes. I think there appears to be a more proactive civil society: NGOs and grassroots organisations who've been working and mobilising, particularly around policing. London as a city has a high Black population, and there are communities that have had particular experiences of police violence and police deaths, and so there has always been very proactive police monitoring and work being done on the ground.

65. Access to data has been really, really important. What we know is that many communities have had very negative experiences and longstanding experiences of encountering the police. Historically, the use of Sus laws; through to stop and search; more likely to be subject to use of force; more likely to be subject to use of equipment like batons, handcuffs, restraints, etc. Those very encounters increase the risks of being subject to the lethal use of police force. The importance of that data has been that we've been able to use that data to demonstrate the disproportionate use of stop and search,

use of force, particularly on Black people, but also on other racialised people. That's been a really important platform for arguing about the need for this data, the need for proper recording on use of force, on stop and search. Let's take that to the next level: proper disaggregated data on who is dying.

66. By no means is it the panacea to all our problems, but at least by having data, you can get a sense, of whether or not policing culture and practice is impacting on Black people differently than their white counterparts. So data can be in a way a good tool for beginning to understand some of these issues Deaths are at the extreme end of a continuum and there are harms and ill treatment associated with oppressive policing practices too: over policing, use of stop and search, use of force, and criminalisation

67. I am asked about the data available on INQUEST's website about deaths in police custody in England and Wales[20], and whether the numbers there show any trend. Probably the most helpful data in terms of evidencing racial disproportionality is looking at the breakdowns that we use within INQUEST's *I Can't Breathe* report[21]. The problem with the data on our website is that some of that is from our own official monitoring that we've done from our case work in the absence of formal data, and then other data was combining some of what the IPCC and IOPC have pulled together.

68. I think moving forward, the Scottish Government should be making publicly available data on deaths across all places of detention. I think it's really important in regard to the Equality Act and understanding the importance of recognising protected characteristics. It's also important because if you don't have that data and if that data isn't disaggregated - given the fact that a lot of these issues intersect: issues around race and gender and disability, neurodiversity and mental health and addictions - you don't understand the

[20] https://www.inquest.org.uk/deaths-in-police-custody
[21] SBPI-00513 'I Can't Breathe' report.

evidence and the issues behind those deaths, how can you then consider the need for policy interventions and policies and practices?

69. I am asked whether I have any other suggestions or recommendations to improve the availability of data. Data can be really helpful for civil society I think if there were proper data collection and publication then of course it can rightly provoke parliamentary debate and discussion and media interest. There's a very clear responsibility on the part of government under Article 2 to ensure that where somebody dies in the care or at the hands of the state, there's a proper investigation. That investigation also includes the duty to try and protect life and to prevent this happening in the future.

70. So the disaggregation and publication is an important opportunity for there to be consideration of the circumstances and context in which someone dies. One of the things that the IOPC do, even though by no means is the data perfect, there is a yearly publication and the information is included in a report. That means every year we'll comment on the data, (which frustratingly doesn't seem to change very much), but it is an opportunity to try and generate media and parliamentary interest in an issue.

Racial Stereotyping of Black men

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

72. INQUEST has got a 40 year history. When we've looked at these issues, we situate police killings or deaths following the use of restraint on Black people within that broader and longer history of police contact and harassment. These by their very nature have been and continue to be the most controversial and their consequent impact on police and community relations has been profound. These deaths connect with the black community's

experience of structural racism and the discriminatory over-policing and criminalisation. They have been the catalyst for considerable public anger and community-based disturbances in response to what is perceived as pervasive state violence with impunity.

73. I've mentioned around the disproportionate stop and search, use of force, and how that then makes death more likely.

74. So, it's important to understand that this is an issue that has had a long-standing context and this isn't new. Avoidable deaths, or institutional killings which is what we would call them, is a culmination of the disproportionate treatment that we've seen, around how racialised constructions of dangerousness, criminality and risk drive up the likelihood of Black people encountering the police and, therefore, the risk of them being subject to use of force.

75. The dehumanisation I'm talking about is about the treatment and the racist troupes and racial stereotyping. Racialised constructions of Black people as a threat, equating them with criminality and dangerousness which then drives punitive responses by police officers, a risk to be managed and controlled whereby restraint and the use of force are the norm, the default with an unwillingness to de-escalate, to contain, to stand back. And the patten we see is to restrain until the person is subdued, stops struggling, ultimately in many cases until death whereby they lose sight of the person as a human being and don't recognise that the struggle against restraint which they perceive as violence, is often borne out of fear, extreme distress and that the struggle is the struggle to breathe, to survive.

76. It's about how that manifests in the way in which people respond to Black people on the ground. But then it's also in the experiences of the families left behind and how those official processes also perpetuate those same tropes.

77. Dalian Atkinson's death culminated in the first prosecution of a police officer for manslaughter in about 40 years. His treatment by police officers and the fact that he was kicked in the head and the indentation of the boot such was the use of force with which he was treated. During the course of that trial of the officers, they were talking about racist tropes, and they really exaggerated the threat and the aggression of Dalian,

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

79. In our evidence to a parliamentary committee, we talked about the death of Seni Lewis by way of example. Police officers involved in the restraint of Seni told the Inquest:

"The sound and tone didn't suggest that he had difficulty in breathing, more something on the inside of him, an aggression and a ferociousness that couldn't be controlled."

80. In that same case, a doctor had described how the officers had treated their son and that it wasn't a human being they were trying to restrain; it was like trying to contain an animal after they tied him up with the straps. This was somebody who was put in leg and arm restraints:

"It seemed like when a hunter had tied the animal. It was an uneasy feeling that I had, that it was not a human being that they were restraining. That is

how he was seen and treated at that point, as an animal, rather than a petrified young man, terrified at the prospect of being put in a padded seclusion room."

81. As Seni's mother Aji Lewis said in our report*: They treated him in such an appalling way. No empathy. No thought. And the same language that comes up at inquests where Black people are concerned They spew out the same thing, 'big, black and dangerous'*. As Margaret Briggs the mother of Leon Briggs a mixed heritage man who died after being restrained by police officers said after his inquest found critical failings by the police and ambulance services*: "We think Leon's race was a factor in the way he was treated by police. He was treated as someone who posed a threat rather than someone in need of help".*

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

83. It's almost that what happens is that the police lose sight of somebody as a human being. The amount of times we at INQUEST have heard language focusing on somebody's strength, aggression, or how they were impervious to pain, and their grunting noises or roaring like a lion. Losing sight of an individual, dehumanising language. This constant reference to aggression, and not understanding that in so many of these cases, particularly cases of people who are in a mental health crisis, you're talking about very, very frightened, people.

84. Because of the thematic work we've done, we have this overview. It is really upsetting and enraging, to be frank, when you see how common it is that the officers, when justifying their behaviour, their violence and neglect, talk about the aggression, the heightened strength, the pain resistance. For me it shows how these racist tropes are very much endemic to policing.

85. This is not without acknowledging that the police have a difficult and challenging job to do, but it's also well-recognised and now well explained in police training that restraint is fundamentally dangerous and that it can kill and indeed has as demonstrated by the deaths and the various reviews set up in response. The use of restraint equipment – handcuffs, leg restraints, holding somebody down, the multiple number of officers – it's been compared to just having a load of footballers just pile onto somebody, to the point where they can't breathe. It can result in somebody's death in a very, very short time. For me there is absolutely no doubting now that police officers across the UK are well aware of the dangers if restraint and the fact that these deaths have caused serious public and political and parliamentary disquiet.

86. I'm asked if I have any comment to make about where the racist tropes come from and why they are so endemic in policing. We could have an examination of colonialism and enslavement and empire, the broader context of racism. Those racialised tropes do stem from the colonial roots of modern British policing and I think that's very well-documented. I think the other thing is that this is now so firmly part of policing. This is not just INQUEST and the families that we work with who are saying this. When you look at the Casey Report[22] that came out. In her examination of the Metropolitan Police, her work found out many of the same issues that we've been talking about for decades, but that just weren't really listened to. When we did the work on the

[22] SBPI-00514 Independent Review Into the Standards of Behaviour and Internal Culture of the Metropolitan Police Service: Baroness Casey of Blackstock DBE CB (March 2023)

Angiolini Review on deaths in custody, there was an important part of that review looked at these issues in detail.

87. So, I think it's well-understood by those who have worked in this field, but the very institutions themselves continue to deny the existence of racism, and in a way, that denial is exactly why it's able to continue.

88. After the murder of George Floyd, when there was a more heightened awareness of these deaths, we were keen to point out that the UK was by no means innocent here, that it had a long track record of similar deaths. That's we put in a very detailed submission to United Nations Office of the Human Rights Commissioner inquiry into law enforcement[23]. They were looking at law enforcement and human rights and the experiences of people of African descent. We also facilitated an opportunity for them to meet directly with some of the families we have worked with and provide human stories of those who had die. It was important for us to show that despite the UK having on paper what looks like a very sophisticated framework for examining deaths at the hands of the police accountability and systemic change was found wanting in so many of these cases.

89. There are a multitude of reports that have come out over the last 30 years as a result of deaths of Black men, and not just Black men, but also people with mental ill health who've ended up dying after the use of restraint. A proliferation of reviews, reports, training materials, videos; recommendations from inquests and inquiries. This has not been an under-researched area, but still today we have got cases that are raising exactly the same concerns. That shows the pernicious nature of racism, and police abuse and misuse of power but also, it's important to also acknowledge that often, you have intersecting issues.

[23]WIT-00087

90. The number of times that mental ill health is relevant. People in crisis who are then subject to lethal force and who die. We see the stereotyping is towards people with mental ill health, the "mad and dangerous". If you happen have an intersection of race and mental ill health, well, the consequences then can be lethal . A number of our cases have involved Black men in mental health crisis. The context of this is long-standing, and I think that is really the reason why it culminated in our decision to do the in-depth research, and our report, *I Can't Breathe.* We knew racism was systemic and how important it was to look at these deaths not in isolation but part of that broader pattern. And how the systems of accountability for racism and racial discrimination in deaths of black people is just not fit for purpose. That's across the UK.

91. The Police watchdog, the IOPC, inquests, the Crown Prosecution Service, have historically failed and continue to fail to scrutinise the role that racial stereotyping might have played in these deaths. There's the pseudoscience around excited delirium and acute behavioural disturbance used to explain away or justify the use of restraint, rather than also looking at the impact of racism and racial stereotyping, and why it was that those officers felt that restraining somebody face-down until they stopped breathing was justified.

92. I am asked whether this stereotyping has an impact on the investigation following a death involving the police. In terms of how it impacts on families and investigations, the first thing I'd say here is the number of Black families who've reported feeling like they were being investigated, rather than the investigation looking at those in whose care and custody the person died.

93. I recall Olaseni' Lewis's mother describing how, when the police watchdog went to meet her at her home, and she started asking questions. She was a lawyer, and therefore legally trained. They said something to the effect of, "Oh, this isn't what we normally expect from the families that we visit." Quite an offensive way of talking to a family. You can take that in whatever way you want, but as I said in my previous statement, it's that very first interaction with

a family that very often sets the tone for how they interact with the investigation and other processes.

94. The impacts are also seen in the very early delivery of the death message. When the family are first told about what happened, the number of times when there is a rather a distorted account of what happened, or that the person who's delivering the news doesn't know anything. They're supposed to then contact somebody else. Then it becomes a matter of trying to find when that person's around.

95. It's difficult to put across how difficult it is for a grieving family who are trying to carry out the post-death cultural and religious practices. Knowing that their loved one's body is the property of the state, as effectively it is, they quite often get denied access to the body because a post-mortem is being carried out, or they're not told about the post-mortem and their rights to have someone there or have a second post mortem.

96. I think any bereavement is difficult but even if you look at it neutrally, somebody's died after being restrained by state agents. That is a really distressing and bewildering situation to find yourself in, and it's very unlikely you're going to know anybody else who's been in a similar situation. Traumatic bereavement is experiencing a bereavement, it's traumatic because of the circumstances of the death but also because of the complexity of what are often very protracted legal processes, and how that interrupts the bereavement process. At a time of significant distress, you've been told that your loved one's dead, it's then really difficult if you can't actually get information from anybody about what's happened. And alongside this you see the misinformation and speculation about what happened, the state narratives that influence and impact on public understanding of who the victim was and the concept of the 'undeserving' victim. That then can really impede a family's ability to get involved very early on. It's absolutely vital that families are informed about their rights at that early stage. The right to have a

forensic pathologist with expertise in restraint present at the first post-mortem or instruct a second post-mortem in the context of restraint-related deaths, is absolutely vital in the context of ascertaining the effect that restraint may have played to the death itself.

97. In terms of the attitude and approach of investigators, racism permeates the state and its institutions, it is institutional and structural. If you begin an investigation and you've got a narrative from police officers about this alleged dangerousness and violence of the deceased, and that their explanation is around denial of their responsibility, then that can very much inform the approach that the investigators take.

98. It's very much about, how do you approach an investigation? At the end of the day, somebody has died in police contact and you need to have a proper understanding of how and why that happened, and that should be that should be approached. We've often said you should investigate these deaths as if potential criminality and wrongdoing has been carried out until proven otherwise, whereas quite often the approach is in the reverse, and it often takes families and their lawyers to try and get the investigation to do the job it needs do.

99. [The impacts of stereotyping and institutional racism are relevant to] discussions about what pathologist to use, what opportunity have police officers been given to confer, to write up their notes together? The golden hour is the importance of separating officers to make sure that they're not talking to each other, that they're writing up their notes independently. Then, importantly, that they give witness statements.

100. I'm asked whether the approach I described, of deaths being investigated with a starting assumption that there is no potential criminality and wrongdoing, is a common theme among cases I've seen. Absolutely. It's almost like they have a narrative in their minds and they're working towards

justifying that narrative and explaining that narrative, rather than approaching it independently and with a very open mind. It's also the way in which we see time and again state denial, defensiveness and a lack of candour from public authorities and police officers, more concerned with reputation management than a properly conducted full and fearless investigation and the pursuit of the truth. There isn't that political concern in the way that I think that there should be because at the end of the day, somebody's died at the hands of the state.

101. I also don't think people fully understand what it's like to be in a situation where you feel that you've constantly got to fight for answers. The pain, the hurt, the emotional toll. These are very, very complex and really protracted processes. People are trying to get on with their lives, and there's a real lack of recognition about the impact this has on people's mental and physical health, and their family, and their overall well-being.

102. I am asked if I have had involvement following any deaths where racialised or stereotypical language was used to describe the deceased. Absolutely, repeatedly in the troupes and stereotypes we see repeated time and again. In fact, I would say it's a feature of all the deaths of Black people that we have ever worked on, which is why I've said I think it's intrinsic to policing. It's part of police culture.

103. I am asked if I have been involved in or know of any cases where no specifically racialised language was used, but race was nonetheless a factor in the person's death. It's more about those racist tropes and the stereotyping and the constant reference to dangerousness; to excessive strength; to aggression; and the whole range of racist tropes that come across all of these deaths. It is worth also flagging up the report that Silvia Casale did after the death of Sean Rigg[24]. She talks about racism implicit in some of the

[24] COPFS-02526 (a)

answers that some of the officers gave to why Sean was behaving as he was.

104. Another thing I haven't really talked about is the narratives around gangs. There's been some research by academic and INQUEST trustee, Dr Patrick Williams, about the problematic nexus between race, gangs, and serious violence as driving an array of oppressive, criminalising policing strategies that disproportionately affect young Black men across England and Wales. There was the controversial Gangs Matrix. This was in the context of the Met and England and Wales, but it was very much around the construct of the gang and that accompanying police discourse and how that label is imbued with notions of criminality. In a sense what we're talking about here is a sense that Black people or racialised people pose a significant risk of harm.

105. That then is used to justify the police response. One of our lawyers, Leslie Thomas, who's a Black lawyer, and chaired the working group to the INQUEST/JUSTICE report summed this up at the report launch. There is nothing about him as a Black man that makes him genetically more prone to die than his white counterpart, but the fact that he is a Black man who could then have a confrontation with police is what makes him more likely to die because of the perceptions that then inform their response. That's why when we talk about this, what characterises so many of these cases is that immediate resort to force, often by multiple officers.

106. Even when you get the opportunity through body-worn footage to see what happens at that scene, particularly on very distressed people, not only is it the immediate resort to force but it's also the shouting of police officers. It's nobody really taking control, nobody just responding in a calm, measured way. Officers are supposed be trained in in de-escalation. That's been well-drummed in to training over the years.

107. I am asked whether I or INQUEST has experience with cases that did not involve connections to terrorism, but where a connection to terrorism was suspected at the time. The one that stands out is Jean Charles De Menezes who was shot dead by the Metropolitan Police. A very highly contentious case. That's a case where in the media aftermath there were all the false allegations of him jumping over a barrier, in a way to justify the fatal encounter on the tube. We did submit some evidence to the Leveson Inquiry Part 1[25] which was about the concerns we had for a long time, which of course we saw after Sheku was killed, about the police's use of the media to provide misinformation.

108. Like when Mark Duggan, a 29 year old Black man was shot dead by police officers. Initial reporting suggested he had fired shots at police officers before he was shot dead. However days later after disturbances across the country the IPPC admitted in a statement that it may have "inadvertently misled" the media and that this was untrue. Two shots were in fact fired by one armed officer. It was later established that he was in fact unarmed when fatally shot[26]. In so many of these cases, misleading false information is put out into the public domain very early on.

109. I suppose it's an illustration, a bit like the gang construct, you know, the terrorist construct. These are played out in the media. They're played out in public domain. You only need to look at the dehumanising discourse and language around asylum seekers. The othering, which then also creates this sense of the undeserving, that somehow the person who died deserved to die, it was their fault , the treatment and violence against them was justified. This is language that's been institutionalised both in the response to policing, but also in the way in which these deaths are often examined within the official legal processes. It's then quite hard to challenge all of that, particularly if the investigation hasn't even addressed the question of race.

[25] WIT-00082 – INQUEST statement to Leveson Inquiry: INQUEST (March 2012)
[26] https://www.theguardian.com/uk/2011/aug/12/mark-duggan-ipcc-misled-media

110. I'm asked whether the investigations I'm speaking about usually address the issue of race. Rarely do the investigations address race, and this is a UK wide issue. This is not just an issue for Scotland. That's the reason why we ended up doing our research and produced our report, *I Can't Breathe*, and then went on to work with the human rights organisation Justice to work on a guide for lawyers, practitioners and coroners on how to address the question of race in their investigations and during inquests, or indeed other legal processes[27]. I think this research very much is the culmination of INQUEST's work around deaths of Black people, recognising that we can't have a conversation about these deaths without recognising that broader context of race and racism. That was the motivation for us doing the work, trying to bring into the public domain the official data and challenge the government claims that ethnicity doesn't impact on the likelihood of dying in police custody. It very much showed for us that it did.

111. What the state often tries to do in these situations is to say, "Well, young Black men are overrepresented in the arrest and detention data.". That assertion can only be sustained because of the way the deaths have been categorised. The official data that we got showed that Black people are seven times more likely than white people to die following police restraint, and the fact that role of racism in these deaths is not substantially scrutinised. It fails to recognise that racism in society has its roots in the power structures. What we're concerned about is that despite years of official recommendations and public campaigns we've failed to stop these deaths occurring and the lethal patten of racial disproportionality continues. But the investigation authorities need to not only investigate race and look at these deaths individually, but we need to look at these deaths within a broader context because they're not isolated events. They're part of a clear systemic problem.

[27] SBPI-00515 Achieving Racial Justice at Inquests: A Practitioner's Guide: INQUEST & JUSTICE (2024)

112. That brings us then to think about the importance of learning, accountability, what does justice look like for families, and the lack of acknowledgement of the race of the person who died.

Restraint

113. One of the challenges of this work - what you tend to see is a very high-profile death. Then you'll see some positive initiatives, often in response to highly critical jury findings. You'll then see the various organisations forced to do something, so you'll see a review or a response to a coroner's prevention of future death report. But then individuals move on, and organisational knowledge isn't shared and is lost until the next time. A load of recommendations that were made and best practice has then not been applied.

114. Looking back over this work it is very clear to me that no police officer in the UK could not be aware that the use of restraint and, in particular, prone restraint is inherently dangerous, and should be used for the shortest time possible. It has been the subject of parliamentary attention and by the policing watchdogs. Whilst a lot of the work that has been done was in the context of England and Wales, such was the high-profile nature of a lot of these deaths it would be remarkable that they would not have generated interest in policing across the UK and not least in Scotland. It is also noteworthy that the former chief constable of Scotland was himself a Deputy Commissioner of the Metropolitan police service during this time span. Indeed, the Police Federation mention the number of restraint related deaths in their communications around Excited Delirium and ABD, Inquests held into some of these deaths have returned conclusions highly critical of the 'unlawful' and 'excessive' or 'disproportionate' force used to the risks posed.

115. Also the risks of restraint were implicit in the police training and guidance. Restraint and prone restraint should be carried out 1) as a last resort, but 2) with a recognition that with it carries a real danger of position asphyxia.

116. The improved professional practice , which was first published in 2013, was about how the fundamental duty of a police officer is to protect and safeguard life. Any use of restraint has to be considered in that vein. A pattern that we've seen time and again, and I think it's really evident and looking at Sheku's death, is that default of police officers to a situation is to go in and restrain and use force, whether that is the use of batons, CS spray or hands-on restraint, rather than stepping back, de-escalation, containing. That response aggravates and exacerbates the situation. It increases the risk of harm to that individual because somebody who is in a state of agitation is often very scared, very frightened and so a rational response to fear and to restriction of oxygen is to struggle to breathe. The mechanics of a restraint death is such that that can be fatal. There is a video called "60 Seconds to Save a Life"[28] which was published precisely to address how fatal restraint can be.

117. I think the point about prone restraint is that it can very quickly go to being a medical emergency particularly when you've got multiple officers lying on top of somebody. The numbers of officers, the weight of those officers. It's not only about the numbers of officers and the immediate resort to the use of force; it's also the fact that it's extremely loud and everybody's shouting. There doesn't appear to be one person who's taking control and one person who's speaking. You imagine somebody who is in distress. Whatever the reasons for that distress, they are in distress and extremely scared, and it's just how that compounds and exacerbates a situation.

Family Liaison

[28] https://youtu.be/ZZO2NvfohZ0

118. I am shown my previous Inquiry statement in which I spoke about the lack of information that bereaved families receive about their legal rights. I am asked if there is anything I have to add on the subject. I've mentioned the real fundamental issue within Scotland and there just not being anywhere like INQUEST for families to go for advice. I don't want to suggest that by any means the situation in England and Wales is perfect because there's a reticence among some organisations to properly inform families about their legal rights. I think whether it's conscious or unconscious, investigation bodies know that if a family contact INQUEST, we will get them a lawyer, and the lawyer will be effectively scrutinising what the investigation body are doing. In effect exactly what Aamer Anwar has been doing.

119. That additional scrutiny can be extremely helpful to the investigators. Unfortunately, some investigators see that as problematic, not recognising the level of expertise that has been built up by INQUEST and members of our lawyers' group. Families have got very legitimate questions that they want answering, and sometimes they're seen as an irritant. Going back to the racist tropes, this idea of seeing families as being angry and unreasonable. I suggest that investigators step into their shoes and imagine, if this were their family member, what they would want, and what they would want and expect.

120. This is also about the law. Going back to Article 2, it's about recognising that this is a legal requirement to give a family of somebody who's died in the care and control of the state a proper explanation for how and why it happened. That should not be something that families have to drag out of the system. It's something that should be given to them. It also raises really important questions about policing more generally, about how the police have to be accountable when someone ends up dying in their hands or following their contact. They can not be above the law. I think the attitude of some police officers, the Police Federation, and indeed some of the senior leadership is that somehow police should be immune from that scrutiny. Absolutely not.

One of the very positive things about the Human Rights Act, is that there should be more independent scrutiny, and a recognition that actually good quality investigations can serve not just the interests of the bereaved family but the public interest.

121. Anybody could get into a mental health crisis and end up in a highly distressed way and end up being in contact with the police and being restrained and dying. I've seen it in my work. So, one of the important things when a death happens, not only do you give a family answers and hold those responsible to account, but where there has been excessive use of force, where there has been criminality, those officers need to be properly held to account. Most importantly, you want to make sure that the learning and the failings that have been identified translate into meaningful change and that all organisations learn from it. Some of the important case law around Article 2, some of those very high-profile inquests that have taken place, it's disappointing to see that that doesn't seem to have translated into the Scottish jurisdiction and in the post death legal processes.

122. It's clear to me, and it's possibly because of the problems with the system in Scotland and the lack of public funding, that there don't seem to be many lawyers who do this kind of work. Article 2 and work around Article 2 doesn't seem to have been as developed in Scotland than it has been in England and Wales and, in Northern Ireland in terms of the conflict and legacy cases. I think there is significant learning that can be gleaned, and Scotland has an opportunity to be a beacon of best practice if this Inquiry can come up with recommendations that the Scottish Government take seriously and act upon.

123. After many, many years of highlighting the inequality of arms in terms of families, in England and Wales we now have non-means tested public funding for families going through Article 2 inquests. That's really important because that is accessible and available immediately after a death. Funding and legal aid is another issue that I think really needs to be looked at as well

as the provision of advice and support. In my last statement I mentioned co-producing a leaflet for families after police deaths with the IOPC, the Chief Coroner's Office, INQUEST and the Home Office[29]. That was a leaflet that was supposed to be handed out to any family where a death has occurred. Unfortunately, the evidence that we have from families that we end up working with is that rarely do families get handed that, despite our best efforts.

124. Because of the nature of our work, this is a very broad area, but there are similarities for all families and the connection and the concerns we have about the way in which all families are treated, but you can't ignore the race dimension when you're looking at the treatment of Black families and how racism impacts on their treatment.

125. I am asked whether I think there are standard practices for police family liaison, after a death has happened involving the police, that may have a worse impact on Black and minoritised groups. In my last statement I spoke about how the perceptions of FLOs is that they are more interested in trying to spy on the family or discredit the family, rather than being a helpful source of practical advice and support[30].

126. I think there needs to be a bit more honesty about the fact that they are investigators. The best practice of family liaison officer that we've seen is where they're honest about who they are and what their relationship is, but they also signpost families to where they can get advice and support. FLOs can play an important role for people where somebody's died, thinking about a range of different areas where the police have to inform somebody of a death not involving the police. That role can be potentially quite useful and helpful. There's an absolute inherent conflict of interest where a FLO is also a

[29] SBPI-00366 paragraphs 37 and 52(b)
[30] SBPI-00366 paragraph 41-42.

serving police officer from the very force in whose care or custody the person's relative died.

127. I am asked if I think there are standard practices for PIRC or other supervisory bodies' family liaison, after a death has happened involving the police, that may have a worse impact on Black and minoritised groups. There's often been confusion about who should deliver the death message, and the importance of a family having the name and contact number of somebody that they can contact, not somebody who's just going on leave or at a weekend who doesn't work, but somebody who is there to provide them the information that they need.

128. Where these relationships break down, quite often you'll have the local police delivering the message. Then they'll have the IOPC or PIRC getting in contact. It can be a lot of confusion about what are the different roles as well as the paucity of information that I spoke about in my previous statement[31].

129. Best practice is the death message is delivered in person by somebody who knows at least some detail of what's happened, or if they don't know, they're honest about it, and they'll give the family somebody to contact who does know more about what's happened. There can be a degree of confusion in those early hours, but families will always remember exactly what they were told in that first conversation. When that then turns out to be inaccurate or untrue, that can cause serious, serious damage.

130. I am asked if I have anything additional to say about the approach of the Crown Office and Procurator Fiscal Service to family liaison in these investigations following a death involving the police. It's unclear to me about how families are informed about the process, their rights in it, where they can get help, and the information that I've seen is not particularly helpful and it's

[31] SBPI-00366 paragraphs 25-30

not human rights-based. I wouldn't call it a developed system by any means. When I last looked, which was probably about a year ago, it was actually really difficult to find any information in Scotland about what to do when somebody dies in custody and detention. That's not a system that is really looking out for the interests of bereaved people, and it's also not satisfying the Article 2 obligations either.

131. I think that any system of good practice is best informed by families themselves. I'm hoping we get funding to do a piece of work with families in Scotland: taking them through the process and asking, "What would have made a difference? What does good practice look like?" because they are the ones who can speak most effectively about what's needed. It's not like there aren't reports out there, like the Angiolini report, the INQUEST Family Listening days that the various agencies in Scotland could look at and see what families report as being good practice.

132. I am asked whether this work with families to improve the system has to be done by INQUEST or whether it could be done by the COPFS and PIRC. Yes, but it's got to be meaningful and not just tokenistic. Independence is key here. Families working with INQUEST or working with others could come up with some very, very good practice recommendations that then the different organisations could then take on board.

133. We produce a handbook and lots of fact sheets and things for families which is a really important resource, but that doesn't take away from the responsibility of the different organisations to create their own. For those to be most effective, they need the input of families and experts like us, or those with experience of these organisations. That's not a costly or a complicated thing to do.

134. I think independence is fundamental. The families that we work with have a lot more trust and confidence in our work because we don't take state

funding, and we're independent. Of course, we work with all the different investigation bodies and the Home Office, the Ministry of Justice, to try and inform best practice, but I think having independent advice and support and information that's created by us and families is important because it also addresses what families actually say they need and want.

Investigation of race

135. I am referred to the recent Justice and INQUEST report 'Achieving Racial Justice at Inquests'[32] and asked what the background to production of this document was. It was a direct response to the research that we had done as part of our *I Can't Breathe* report. At the same time, we had also produced a report looking at deaths of Black and racialised prisoners. Both reports reviewed the way in which investigations and inquests were being carried out and found the lack of any meaningful examination of the potential role of race and racism.

136. Justice had approached us before we completed that report, saying that they were interested in looking at this area of work, so we joined forces. We were involved in a working group. It had lawyers who do family representation, but also those that represent the state, a couple of academics, a bereaved family member, INQUEST, and myself. The working group was particularly useful in informing the work. We were able to do some data analysis. Although this was a report about deaths in custody and detention, it has the potential use for really any deaths where there was concern about whether or not race or racism informed the treatment of who died. For example, there's been a lot of concerns across other areas around the intersection of race and health.

[32] SBPI-00515 – Achieving Racial Justice at Inquests: A Practitioner's Guide: INQUEST & JUSTICE (February 2024)

137. The intention of the report was to give a broader context to look at these issues across police, prison, mental health. This guide provides lawyers representing families bereaved by deaths in police custody, prisons, immigration detention, and mental health settings with the legal expertise to raise the potential role of race and racism at inquests. It also provides foundational knowledge and strategy to coroners to ensure they satisfy their duty in fully investigating the circumstances in state custody deaths. It's a guide about the broader context in understanding race and racism and how it impacts across the criminal justice and mental health systems, the issues to look at, the questions to be raising throughout, whether it's the inquest or whether it's the investigation. It's an accessible toolkit for practitioners and coroners but equally relevant to all those working across these areas in Scotland. Publicly acknowledging and investigating issues of racism are necessary first steps towards achieving justice and preventing further harm and deaths.

138. The response we've had has been very positive. We know people are using it, so it's a practical guide. We'll monitor how it's implemented and whether or not it's making any difference on the ground.

139. I am asked what the barriers to having race explored as a possible cause in investigations, inquests and inquiries. It's very rarely that it is explored.

140. Because quite often families are demonised, they have had negative experiences of the police or other public authorities, or they're worried about doing reputational damage to the wider family or being dismissed. As our report I can't breathe revealed some lawyers lacked the confidence to properly raise these issues at the outset. That is one of the reasons why we decided to do this guide, because it is a toolkit to try and help people understand how to raise this. Also, a lot of coroners being reluctant to raise these issues. I think sometimes it's seen as the too difficult area to tread into because by exploring race and racism, you're not directly saying that

somebody's actions were racist. It's about people understanding that racism is structural, it's systemic. Just because racist language wasn't used doesn't mean that the death isn't informed by racist attitudes and assumptions. That's an important distinction.

141. I remember being in a meeting last year with the IOPC in a very high-profile death of a Black man, asking the investigators, "Are you investigating race and the significance of this death as a Black man subjected to lethal force?" They stumbled their way through an answer and then said, "Well, if you've got any help that you can give us about how we should address this, please get in touch." To be honest, I wasn't that surprised, but I also thought it was astonishing that after all these years, after all this evidence, after the Casale review of their own investigation process, they should, know how to do this.

142. If you look at these deaths collectively you see the patterns and you see how you simply cannot ignore the question of "was the fact that this individual who died was Black relevant to how they were treated?". When you look at disproportionate level of violence and neglect and the excessive response to the people who died, you see that pattern very clearly.

143. I think, ultimately, and what re recommended in our report was that any death of a Black person should automatically see race being part of the investigation by all the relevant agencies – the IOPC, the coroner, the Crown Prosecution Service, the PIRC, and COPFS. Lawyers should raise it automatically on family's behalf. Likewise, if there are other areas around discrimination. Mental health is also relevant. I think we need to be much more aware of these issues. We've got to acknowledge here that somebody has died in an often really horrendous way, and we need to do all we can to learn about how to stop it happening in the future.

144. I am asked, in terms of consideration of race in investigations, whether I see any differences between the way different bodies (the police, PIRC and

similar supervisory bodies, and COPFS or prosecuting bodies) approach it. I am asked whether they face or present different barriers to the investigation of race. From my experience the issues are the same across the different agencies. The guide that we've done is for everybody concerned. In terms of the Crown Prosecution Service, there's the unwillingness to investigate deaths at the hands of the police as a potential crime. It is about mindset. If you're doing these kinds of investigations, you need to have an open mind. You need to start from the premise that somebody is dead because of police involvement. You need to properly explore and be alive to the fact that this could be a potential crime by police officers. You robustly explore.

145. Our view's always been that should be the starting point and let the evidence prove otherwise. Whereas the experience that we have is that they start from the presumption that there hasn't been any criminality or wrongdoing. That also points to the concerns, and these are long-term concerns, about police officers giving evidence, giving witness statements, and then the lack of robust questioning.

146. Lawyers described that institutional reluctance to investigate police racism. That's no different whether that's the Crown or the police or the police watchdog. The IOPC have got guidelines for handling allegations of discrimination under the Equality Act because race is obviously a protected characteristic. That's UK-wide.

147. The lack of a statutory duty of candour is also relevant and the need for Hillsborough Law, the Public Authority Accountability Bill to be implemented. It's so important that it applies to all law enforcement agencies and public authorities because these investigations are characterised by the lack of candour and that culture of denial and defensiveness.

National Oversight Mechanism

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

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

150. The proposal for a National Oversight Mechanism has come about because of our frustration of working over 40 years on deaths in all forms of custody and detention (and other areas, like Hillsborough and Grenfell), where we've tried to enhance the preventative potential of inquests and inquiries. We have worked with families and their lawyers in order to ensure that investigations are a forum in which systemic failings can be identified and essential changes can follow. Yet our work has highlighted how that opportunity for prevention and for social change is undermined by the lack of a framework to monitor compliance with, and/or actions taken in response to, findings and recommendations that emerge from post-death investigations, including inquests, inquiries and official reviews into state related deaths. Every year, we see preventable deaths occurring because of systemic failures to enact meaningful change.

151. One of the biggest frustrations is that after critical inquiry or inquest reports, the consistent response of governments is to say those hollow words, "lessons will be learned." Yet you do not see consistent, proactive learning actually impacting things on the ground. Potentially life-saving recommendations too often just end up on a shelf or disappear into the ether until the next death. Quite often You'll hear of the most horrific, brutal restraint death, by way of example. There may well be some immediate response and some review or working group established, but then people

move on. The Angiolini review into deaths in custody[33] is a really good example I can come on to here. Those recommendations and related action just peters out.

152. INQUEST have identified a real accountability gap. It is difficult to find out what has happened to the countless recommendations that have come out of investigations. Official responses to recommendations often lack detail and are a 'cut and paste' or formulaic response to some of these reports. There's a complete lack of transparency on the extent to which public bodies are actually implementing recommendations. Quite often, recommendations are not analysed. There's no central location where the public can view the progress of any of these recommendations.

153. Shamefully as well, families rarely are informed as to what changes have actually happened as the result of an investigation. It's a complete disservice and insult to bereaved families. What families tell us time and again is that nothing can bring their loved one back, but they want systemic and meaningful change so that nobody else goes through a similar experience. We've seen a lack of candour and that culture of defensiveness from state bodies towards change and learning during investigations, more concerned about reputation management and protecting their policies and practices than learning and improvement. Often, you will find that state lawyers will argue against recommendations being made, or they'll dismiss the need for recommendations because of the passage of time, rather than seeing the scrutiny afforded by an in-depth look at how and why somebody dies as an opportunity to avoid another death taking place.

154. So, we developed the concept of the National Oversight Mechanism, which would be an independent body that we believe would help improve the value and impact of these post-death processes and increase public trust in what

[33] SBPI-00496

looks on paper as quite a sophisticated framework for death investigation. What we hope the National Oversight Mechanism would do would ensure that information on the progress and implementation of post-death recommendations is easily available. Not only to bereaved families, but it would also be available to those conducting investigations. A more robust system of oversight to recommendations could help facilitate greater engagement with and response to recommendations which could, in turn, to prevent deaths and serious harm.

155. There's also a human rights case for establishing a National Oversight Mechanism. The Article 2 obligation has a wider obligation than simply protecting the right to life and ensuring that deaths are subject to proper investigation. It must also learn from the circumstances of deaths and work to prevent similar instances occurring. Lord Justice Sedley in R (Lewis) v Mid and North Shropshire Coroner [2009] EWCA Civ 1403[34] observed that the obligation to investigate is not only to identify officials or authorities who bear responsibility for what's happened, but to learn lessons for the future. A National Oversight Mechanism would be a mechanism to ensure proper oversight of recommendations and what has happened to them.

156. There's no central responsibility to ensure actions are taken in response to key recommendations. The responsibility to follow up issues arising from investigations, inquests, FAIs and inquiries doesn't sit within the remit of any of the regulation or investigation oversight bodies such as HMICS in Scotland. Unless they regularly receive the outcomes and the detail from investigations and FAIs, how can they take forward some of the issues that came out of those deaths during their inspections? Equally, there's rarely oversight by government or Parliament. Occasionally, you'll have a Parliamentary Select Committee that might look at a particular inquiry and look at the progress of investigations, but the absence of that responsibility to

[34] R (Lewis and Others) v HM Coroner for the Mid and North Division of the County of Shropshire and Others - Case Law - VLEX 792591005 para 11

follow up investigations means that unless bereaved families, lawyers or organisations like INQUEST follow up, there's no pressure to implement change.

157. The other issue is that post-death investigations and inquiries are extremely expensive and cost a lot of money to the public purse. And of course, the emotional human cost cannot be overstated nor the psychological impact of hearing about another death in similar circumstances. The absence of an effective system to monitor what happens to the fruits of these inquiries and investigations is a real disservice to the bereaved families and the public interest.

158. So, the National Oversight Mechanism would have three functions.
    a. Collation: it would create and manage a publicly available database collating all the recommendations made following post-death processes and highlighting the public agencies that the recommendations are addressed to. It would make clear when an agency has implemented, partly implemented, rejected or indeed not responded to a recommendation. The agencies in question should be required by law to respond with the correct information to the Mechanism. It would categorise recommendations by type of death, detention setting and protected characteristic. That would be a really vital hub then for inquiry panels, lawyers, researchers and the public. It would also mean that you would be able to track what has actually happened.
    b. Analysis: based on the information collated, the mechanism could issue regular reports to analyse the emerging themes and patterns. INQUEST believes the Mechanism should have an annual report that would bring together information on recommendations made to, for example, individual police forces or NHS trusts. It would also carry out thematic analysis on recommendations related to protected characteristics, such as race, gender, disability or other emerging

concerns. Of course, that goes to the point about impacting on policy, policy change and intervention.

c. Follow-up: The mechanism would be equipped with robust powers to follow up and alert the relevant bodies in order to escalate its concerns. Where it saw that there were a pattern of restraint-related deaths, for example, that had seen repeated recommendations and various agencies not responding or not enacting change, then it could escalate its concerns to ministers, secretaries of state, or importantly to Parliament and parliamentary committees. In other circumstances it could raise specific areas of concern to the Crown Prosecution Service or the Crown Office, the Health and Safety Executive, or the Equality and Human Rights Commission or the Human Rights Commission in Scotland, and also the National Preventative Mechanism, which is particularly important, given that they monitor places of detention.

I gave evidence to the Justice Committee follow-up to their inquiry into the coroner's service[35]. I also gave evidence to the House of Lords Statutory Committee on public inquiries[36]. This Inquiry will no doubt have found it challenging to find a central location for where the pertinent reports and recommendations to inform this inquiry are. Indeed, INQUEST have been relied on for quite a lot of this information. Whilst I think it's appropriate an NGO like ours does some of this work, there is a responsibility on the part of the state to have a properly accessible mechanism for being able to document action and inactions and any changes made following state-related deaths, because time and time again we see the same recommendations being made.

159. Bereaved people have got involved in inquests, reviews, inquiries, because their motivation has been to try and ensure that something positive comes out. With goodwill and often at great emotional cost, they've relived the worst

[35] https://committees.parliament.uk/oralevidence/14294/pdf/
[36] https://committees.parliament.uk/oralevidence/14719/pdf/

aspects of their life. They've come together and made really well-informed recommendations for how things could be better, and then to see those recommendations being dismissed or ignored, that really does undermine public trust and confidence in the very mechanisms that the state has. It's a betrayal of those families. And it is repeated time and again depending on the political scandal being investigated.

160. Lady Elish Angiolini's report was set up in response to disquiet about the experiences of two Black families after the restraint deaths of Sean Rigg and Olaseni Lewis. It's the first time there'd ever been an in-depth review of all the post-death processes. I think in a relatively short amount of time we were able to uncover a whole wealth of important evidence that was then used to formulate very clear evidence-based recommendations. INQUEST facilitated two family listening dates so that Lady Elish Angiolini could hear directly from bereaved people who'd been through these experiences. They developed a really good relationship of trust with her, and the fact that I was appointed as a special adviser I think was also important, because it meant that we were able to draw on that wealth of information and evidence that INQUEST had gathered, we could share with the review. We were also able to facilitate meetings with INQUEST lawyer group members with expertise in this area as well as other key people across policing, health, investigations and inquests. The review took very, very seriously the experiences of families, and so those recommendations were informed by their experiences and views.

161. To then see that those recommendations have still not been enacted is really frustrating and actually makes me really angry. What is the point of all these processes if the state can just dismiss them and not be held accountable for that? My view is that in reality that report is sitting on a shelf somewhere. Every now and again, the dust is removed, and somebody has a little look because they've been asked a difficult question about what's happened to some of the recommendations.

162. One of the things I've reflected on since being involved with the Angiolini report is, the danger of making too many recommendations because it gives the government a really good excuse not to answer all of them. What government do is they group them together and then say, "the majority of these have been achieved." How have they been achieved?

163. In the absence of a National Oversight Mechanism, how do we ensure that where a public inquiry makes recommendations, that there is a proper process for monitoring and following up on what happens to those recommendations? There was some good practice in the Manchester Arena Inquiry, where the Chair called back the relevant organisations to report on what they had or hadn't done in response to the recommendations. What subsequently transpired was there was lots and lots of action being carried out, but it was very much in response to the callback to come and report on what had actually happened. I note the positive statement in response to the Infected Blood inquiry that Sir Brian intends to convene a meeting in a year to monitor progress in response to his report.

164. In the Grenfell Public Inquiry that INQUEST were involved in, I wrote to the Chair asking him to do a similar thing, given that the Inquiry was still ongoing. He refused, saying he didn't have the powers to do so. I think that's debatable, given that different inquiries have conducted a different approach, but my view is that any inquiry that really is committed to ensuring that there's learning and that there's change on the ground needs to ensure that they are either performing that function themselves or that they're recommending that the government set up a select committee or an advisory group to monitor the implementation, because otherwise there is a real danger that an inquiry report can just end up on the shelf. Given the importance of this Inquiry and the evidence that it's taking, it could perform a really important function and it could really operate as a blueprint, not just across Scotland but other jurisdictions. And of course, this must involve the family and their lawyers.

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165. One of the things we were saying to the House of Lords Committee is that the legislation needed to be changed to ensure that there was a clear process of follow up and scrutiny under the Inquiries Act 2005. It's absolutely vital that there is a follow-up mechanism.

166. We're really hoping that when the Grenfell Inquiry Second Report comes out, that they're going to endorse our National Oversight Mechanism. The London Mayor has supported it in all of his submissions to the Grenfell Inquiry. Lady Elish Angiolini took on board our concerns and recommended an office for Article 2 compliance. There was a very important report that the organisation Justice did called "When Things Go Wrong: The response of the justice system."[37]

167. I was on the working group to that along with the former Chief Coroner Peter Thornton, the judge Sir John Goldring who presided over the Hillsborough Inquests, there were state lawyers, family lawyers, myself, some academics, chaired by Sir Robert Owen, who has presided over a number of public inquiries. They also supported the proposal for a National Oversight Mechanism, as have many NGO's and parliamentary committees and in his evidence to the Justice Committee's follow up Inquiry to the coronial system, the Chief Coroner said INQUEST had identified a gap in regard to the oversight and follow up of Prevention of Future Death reports.

168. I'm really pleased at how well it's been received, but I think one of the things that surprised a lot of people is the fact that this doesn't happen anyway. I think people find it staggering that you have all these sophisticated post-death processes and yet the follow-up of recommendations and holding people to account for what they've done or not done is not seen as a significant part of the state accountability.

[37] https://files.justice.org.uk/wp-content/uploads/2020/08/06165913/When-Things-Go-Wrong.pdf

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169. It's not just about the loss of human life and the traumatic bereavement that people go through, it's also about how these cases often give rise to significant political scandals. If you look at Infected Blood, Child Abuse, the Post Office now, you get a corresponding loss of trust and faith in institutions of the state. By developing this mechanism, I think our hope is that where contact between the citizen and the state ends up in disaster or death, the post-death processes need to be on a much more secure footing. I think the National Oversight could make a real difference to what is a really sensitive and important area.

170. I am asked whether the National Oversight Mechanism would benefit from covering the whole of the UK. Absolutely, because we're talking about cross-jurisdiction learning and accountability here. I see that it adds value. The Independent Review of Deaths in Prison conducted in Scotland in response to the deaths of Katie Allan and William Lindsay in Polmont recommended that the National Oversight Mechanism be established, in part because of their own frustration about how some of these deaths had been investigated and the recommendations not taken forward.

171. I think it would also signal a commitment to learning and accountability on behalf of the Scottish Government. One of the things that Sheku's death has clearly raised significant disquiet about is the treatment of bereaved people, the quality and rigor of investigations, the role of the police and issues around race and racism, and the use of force. If you have a National Oversight Mechanism, it would signal a real commitment to be accountable for what comes out of this Inquiry, and an inquiry that has cost the Scottish Government a lot of money.

172. There is value of a National Oversight Mechanism irrespective of whatever administration is in power or which jurisdiction it is active in. This is relevant as a body across the UK. We believe a Mechanism would need to be

structurally and operationally independent of government by being accountable to Parliament.

Articles 2 and 14 ECHR

173. I am asked whether I have any further comment to make about compliance with Article 2 by the police or broader criminal justice system. In a way it's been members of INQUEST Lawyers Group and working with INQUEST that have made the Human Rights Act a living instrument. It's had a really significant impact on the investigation of deaths in custody. It resulted in the Prisons and Probation Ombudsman being set up to investigate prisoner complaints and deaths in prison in England and Wales. It resulted in the IPCC being set up. Those organisations were set up on the back of campaigning by bereaved families and INQUEST in highlighting some of the inherent problems with the investigation processes, particularly their lack of independence.

174. I was surprised when I started working on Sheku Bayoh that that culture wasn't so established within Scotland. I think the PIRC was relatively new. Then of course there was no independent investigation body for deaths in prison. There was the question whether or not the Fatal Accident Inquiry process really engages Article 2 in the context of ensuring a very wide-ranging investigation into deaths in custody. I was shocked to find out that there were no mandatory FAIs into deaths in mental health detention. For me, it's an area that could be further developed. Going back to some of the key elements of Article 2 and the Armin judgment: is the guiding principle really there, about what function an Article 2 investigation should serve.

175. I am asked whether I have any comment to make about Article 14 ECHR, as it applies to and imposes obligations on investigating bodies, and in particular in relation to deaths of black and racialised people involving the police. The motivation for our research on this, both in terms of police and prisons, was a

recognition that Article 14 has not been used or understood by lawyers across the jurisdictions. Article 14 was clearly significant in imposing obligations on authorities to investigate questions of racism and discrimination. What's frustrating is the fact that this was flagged up at a very, very early stage in the investigation into Sheku's death as an area that should be explored and it wasn't taken on board. That is really frustrating because had it been, the family might have felt more confident about the investigation process and the investigation a more meaningful one.

176. I am asked whether I have any recommendations for improving awareness of obligations under Article 14. It should go without saying that anybody who is investigating death should be aware of the key human rights obligations of investigations, not just about Article 2 but of course about Article 14. Recognising that protected characteristics (I'm using "protected characteristics" because it's what's in the Equality Act). It's not just about deaths of black people; it's also about the intersection between race and mental health, disability.

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

May 23, 2024 | 8:36 AM BST
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