Critical Criminological Perspectives

Deaths After Police Contact

Constructing Accountability in the 21st Century

David Baker

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For Ken Baker (1925–2014), who could imagine a life beyond the factory

Preface

In June 2011 I was in a café in London with a former colleague. The ubiquitous rolling news played on TV. It announced that PC Simon Harwood, the officer at the centre of the death of Ian Tomlinson in the G20 protests in London in May 2009 was to be charged with his manslaughter. In the weeks that unfolded, I thought more and more about the idea that, so far as the state is concerned, accountability is legitimately constructed in all cases of death after police contact (DAPC). The official narrative is that these cases are investigated independently and rigorously, their findings are made public, and the police no longer 'police the police'. True, numerous cases going back over a long period of time have been highly contentious. Anybody with knowledge of this issue could instantly reel off the names of Blair Peach, Roger Sylvester, Shiji Lapite, Harry Stanley, Jean Charles de Menezes, Ian Tomlinson, Azelle Rodney, or Mark Duggan. There is no institutional denial that the people who die after contact with the police are disproportionately from BME (Black or Minority Ethnic) groups, or that they tend to have issues with mental health or substance abuse. In short, few doubt that people from marginalised groups in our society are disproportionately more likely to die after police contact than any other group of people. There have been numerous cases where a verdict of unlawful killing has been returned by juries in the coroner's court, for example the deaths of Christopher Alder and Ian Tomlinson, albeit that none of these cases went on to be prosecuted

successfully in criminal courts. I wanted to know how this state of affairs existed in our society and what that said about society's relationship with police and the state.

This book is not just about the people listed above. It is about a wide variety of people who have died in cases of DAPC, some of whom are barely heard of outside their local area. It is not just about people who are shot dead by police, or hit with batons. It is about people who die drunk or from swallowing drugs while in custody; about people who die in accidents in police pursuit chases; and about people who die as a result of neglect and an absence of care while in custody. Campaign groups and families have long fought for greater police accountability and more transparency in cases of DAPC, citing miscarriages of justice, asymmetrical power in the investigative processes and the failure of police regulators to consider cases of DAPC as potentially being a crime from the outset. The more I thought about these complex issues, I wanted to know: how *is* accountability constructed in all of these cases—because so far as our state and legal system is concerned, accountability *is* manifest, whether we or not we are happy with this.

This book is about deaths after police contact in England and Wales and how accountability is constructed in the aftermath of these cases. That starting point was the genesis of a PhD I began in January 2012. This book represents an updated and reworked version of my PhD. My research uses two documentary datasets, one from verdicts recorded in cases of DAPC by juries in coroners' courts, the other from investigation reports published by the IPCC (Independent Police Complaints Commission) into these cases.

In some ways the book follows a classic social-science approach: it examines a relatively peripheral issue in order to shine a light on wider practices that reflect socio-legal norms and values. In this case, people who die after police contact tend to be labelled as coming from peripheral groups in society, and the issue of death after police contact is relatively peripheral in the wider scheme of police activity in England and Wales. The book aims to show that the issue of DAPC can tell us quite a lot about how policing is and how it might be, in addition to critically examining what we mean when we use the term 'accountability' in relation to public services. It considers the symbolic and practical aspects

of policing and accountability in both the wider context but also more specifically in relation to the issue of DAPC.

I do not claim to have written a definitive text, nor do I profess to have an 'answer' to this 'problem'. To paraphrase Brecht in the *Life of Galileo*, academic enterprise is an exercise in ignorance reduction. I hope this book will reduce, in some part, our ignorance of the issue of death after police contact.

Acknowledgements

First, I am very grateful to Marcia Rigg for her blessing in allowing me to discuss the events leading to the death of her brother, Sean, and the events after his death including the initial IPCC investigation, inquest and subsequent reviews to date in a public forum.

Second, thank you to Helen Shaw and Deborah Coles at *Inquest* for answering endless questions and giving me access to narrative verdicts—without these, there would be no book.

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Last, but by no means least, to Jane Hinton for love, understanding and putting up with me throughout the process of writing this book. I must have been unbearable to live with at times.

Contents

List of Abbreviations

ACPO	Association of Chief Police Officers
BMA	British Medical Association
BME	Black and Minority Ethnic
CAD	Computer Aided Dispatch
CP	College of Policing
DAPC	Deaths After Police Contact
DDO	Duty Detention Officer
DPS	Directorate of Professional Standards
ECHR	European Convention on Human Rights
FFLM	Faculty of Forensic and Legal Medicine
FME	Forensic Medical Examiner
HAC	House of Commons Home Affairs Select Committee
HMIC	Her Majesty's Inspectorate of Constabulary
HRA	Human Rights Act
IAP	Independent Advisory Panel on Deaths in Custody
IPCC	Independent Police Complaints Commission
JCHR	Joint Committee on Human Rights
MDT	Mobile Data Terminal
MOJ	Ministry of Justice
MPS	Metropolitan Police Service
NAO	National Audit Office
NCPC	National College of Police Chiefs
NGO	Non-Governmental Organisation

NPIA	National Police Improvement Agency
ONS	Office for National Statistics
PACE	Police and Criminal Evidence Act 1984
PCA	Police Complaints Authority
PCB	Police Complaints Board
PCC	Police and Crime Commissioner
PNC	Police National Computer
PSD	Professional Standards Department
SLaM	South London and Maudsley Trust

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Introduction: Contextualising Death after Police Contact

Sean Rigg was forty when he died in 'the cage' in Brixton police station on 21 August 2008. He was a rap artist and singer, and had released a CD of his own music and lyrics. He was widely travelled and was considered to be a charming and intelligent person. Sean was black, he had a formal diagnosis of schizophrenia which was controlled by medication. His condition was usually well managed, enabling him to live an active, independent life, but could deteriorate rapidly if he ceased taking medication. Sean lived in a community mental health hostel in south London and was in regular contact with his family, particularly his sister, Marcia, who was considered to be an 'integral' part of his care team (Lakhani 2012). His consultant from the South London and Maudsley Trust (SLaM) considered him to be a physically fit and healthy person.

SLaM, who were responsible for Sean's duty of care stated that from 11 August 2008 he was 'in need of acute treatment and that his placement in the community was unsafe' (Casale et al. 2013: 42–3). SLaM failed to respond to multiple requests from the hostel to meet with Sean in the two weeks prior to his death. Hostel staff called police five times over a period of three hours on 21 August to request officers' attendance due to a relapse in his mental health condition which caused an extreme

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psychotic episode. Police did not attend the hostel, but did respond to an emergency call from a member of the public when Sean was seen acting oddly while semi-dressed outside a residential location. Four officers arrived in a van; they failed to recognise that he had mental health issues. He was arrested at 19.40 for allegedly assaulting a police officer and for an alleged public order offence (IPCC 2012b: 37). Thereafter, he was detained using handcuffs and prolonged prone restraint, following which he was also arrested for the theft of a passport—it was his own expired passport which he kept on his person for identification purposes (Casale et al. 2013: 59). He was then put into the back cage of a police van and driven at speed to Brixton police station. Upon arrival at 19.53 he was left in the van for ten minutes. He was then removed at 20.03 in a collapsed state and placed in a chain metal structure known as 'the cage', adjacent to the custody suite but external to the building. The Forensic Medical Examiner (FME)[1] attended him at 20.13 and requested that an ambulance be called. An ambulance was called at this point, but not an emergency ambulance. At 20.24 the FME was recalled as Sean was not breathing, and at this point an emergency ambulance was called. Officers attempted mouth to mouth resuscitation and used a defibrillator without success. Sean died after less than one hour in police custody. It took more than thirty minutes for anyone to administer medical attention to him.

As per the protocol, the Metropolitan Police Service (MPS) referred Sean's death to the Independent Police Complaints Commission (IPCC). An IPCC team of investigators arrived at Brixton police station around midnight on 21 August. At around 08.00 the following morning it was announced that an independent investigation would be carried out into Sean's death. The investigation report into his death concluded in February 2010 but was not made public until 15 August 2012. A coroner's inquest, heard in public, before a jury, began on 12 June 2012 and concluded on 1 August 2012, nearly four years after Sean's death. The inquest considered evidence that the IPCC did not find, did not seek or did not use. This evidence was gathered principally by Sean Rigg's family. The result was a jury verdict that differed considerably from the findings of the IPCC investigation report. The purpose in opening this book with the death of Sean Rigg

[1] Previously known as Police Surgeons. The Metropolitan Police Service (MPS) use the term Forensic Medical Examiner; Kelly et al. (1996) note the wide variation of terms used in this role.

is twofold. First, to illustrate the types of events and issues that may lead to cases of DAPC. Second, to illustrate how different regulatory systems produce different investigations into such deaths, leading to a relational system of accountability construction in these cases. By relational I mean dependent upon the contexts in which accountability is constructed. By accountability construction I mean the processes and mechanisms that are used to produce accountability in cases of DAPC. The following section sets out aspects of both the IPCC investigation report into Sean Rigg's death, and the inquest verdict recorded by the jury.

Relational Accountability in Cases of DAPC

The jury verdict in the coroner's court ran to three pages compared to the 162-page IPCC investigation report (IPCC 2012b). The IPCC report is striking in its level of empirical detail regarding witness statements and timings of events. Below, there is a brief discussion of issues covered by the jury verdict and IPCC report regarding mental health, restraint, Computer Aided Dispatch (CAD) response and securing evidence. It will become clear that different organisations using different processes construct different types of accountability, underlining the relational aspect of accountability construction in cases of DAPC.

Mental Health and Restraint

The coroner's jury criticised SLaM for failures or absences in communication, crisis planning, risk assessment and treatment. It stated that SLaM failed to put a crisis management plan into place and that there was inadequate risk assessment of Sean Rigg. Communication between members of Sean's clinical team and also between the team and his family was considered 'less than effective'. Furthermore, they recorded that communications between police, SLaM and Penrose (the hostel provider) were 'inadequate'. The IPCC investigation report makes little comment on SLaM, primarily because the remit of the IPCC is to focus on police action or omission rather than the wider circumstances which contributed to the death of Sean Rigg. Mental health issues are intimately linked

with police interactions with marginalised groups, and with the issue of DAPC (Adebowale 2013). For the IPCC not to consider this issue suggests either a lack of knowledge or interest on their part; it suggests that the initial parameters that provide a framework for their investigation of these cases are at best flawed and at worst blinkered. By failing to consider the role of SLaM in the death of Sean Rigg, the IPCC overlooked why police were in contact with Sean in the first place. His death illustrates failings in two public services, as distinct to purely the police, and this is a consistent theme in cases of DAPC.

The jury stated that upon arrival at Brixton police station it should have been reasonable for the police to recognise there was cause for concern about Sean Rigg's physical and mental health, and this should have led to an assessment of these conditions. That this did not occur represented: 'an absence of actions by the Police and this was inadequate'. The failure to acknowledge issues relating to Sean's physical and mental health is linked to the role of police in these cases: are they enforcement officers or peace officers? Do they focus on the criminal justice aspect of their role when dealing with vulnerable groups, or do they focus first and foremost on the preservation of life and the welfare of the individual?

The IPCC report focuses on Sean Rigg's alleged behaviour during transportation to Brixton police station, noting that three of the officers described him spinning around on his back and walking around the sides of the van walls on his feet, leading them to charge him with a public order offence (IPCC 2012b: 54). During the inquest this behaviour was demonstrated to be a physical impossibility by expert witnesses (Casale et al. 2013: 66). The IPCC report spent several pages discussing the inability of officers to acknowledge that Sean had mental health issues, noting that 'it is of some concern' that they did not do so, despite describing his behaviour as 'strange by anyone's standards' (IPCC 2012b: 105). The inability of officers to recognise mental health issues meant they were not procedurally obliged to take into account Standard Operating Procedures (SOP) regarding mental health issues when approaching, arresting, restraining, transporting and caring for Sean Rigg in custody (IPCC 2012b: 110). Had they recognised mental health issues they would have had to conduct a risk assessment and attempted to de-escalate the situation rather than use restraint in the first instance. As noted above,

the type of approach determines the type of actions (or omissions) that are adopted by officers.

The jury was critical of the police use of excessive restraint, stating that:

> 'The length of restraint in the prone position was … unnecessary. It is the majority view of the Jury that this more than minimally contributed to Sean's death.'

The level of force used during the restraint phase was deemed 'unsuitable'. The jury criticised an absence of leadership and questioned whether: 'police guidelines or training regarding restraint and positional asphyxia were sufficient or were followed correctly'. In the IPCC report, restraint was assessed by an expert from the Association of Chief Police Officers (ACPO) commissioned by the IPCC. He noted that the recognition of 'impact factors' such as mental health issues could have affected the officers use of restraint had they acknowledged the existence of such factors. The section concluded:

> 'This investigation has uncovered no evidence to suggest that the techniques used by the officers and the level of force applied during the arrest of Mr Rigg was disproportionate or unlawful.' (IPCC 2012b: 113)

The coroner's jury and the IPCC clearly have subjective differences in measurement and this points to one way in which accountability may be seen to be a relational concept. In this case, measurement criteria determining acts as proportionate and lawful might be quite different to those which assess acts in terms of whether or not they are legitimate and desirable.

Computer Aided Dispatch (CAD) and Scene of Death

The jury criticised CAD responses to emergency calls from the hostel as 'an unacceptable failure to act appropriately'. Furthermore, the police response to these calls was 'unacceptable and inappropriate'. Moreover, they stated that police failed to secure an ambulance as quickly as possible. The IPCC report sets out a detailed description of issues relating

to CAD systems and operation. For example, the CAD operator notes on the CAD record, which would have been available to police on their Mobile Data Terminal (MDT): *'he must have mental health issues'* (IPCC 2012b: 77, italics as original). Official reports into cases of DAPC stress the importance of officers referring to existing records to access information when dealing with potentially vulnerable individuals (see, for example Leigh et al. 1998; Best et al. 2004; Hannan et al. 2010; ACPO 2012). A good deal of space is spent in the IPCC report discussing the general principle in CAD of sifting calls into levels of gravity, and of the overall response rates by the local borough police and MPS in general. The IPCC section on CAD response concludes apologetically: 'Unfortunately, in many circumstances it is just not possible for the police performance to match up to the often unrealistic public expectation of them' (IPCC 2012b: 104). One may question how an organisation with a mission statement that states an intention to promote public trust in the police is able to record such an observation.

In the IPCC report, the inability of the police to secure both the scene of the arrest and the scene of death mildly concluded:

> 'It does appear that little consideration was given to the evidential opportunities that may have existed at the site of the arrest.' (Ibid: 122)

A number of pages discussing the issue of CCTV are prefaced with:

> 'The whole subject of the CCTV at Brixton police station is an immensely complicated one.' (Ibid: 123)

Yet the family of Sean Rigg were able to secure the CCTV footage from inside Brixton police station while the IPCC were apparently not. The issue of securing evidence is highlighted regarding the independence of the IPCC in a number of academic texts (see Savage 2013a, b; Smith 2009a, b) and official reports (Casale et al. 2013; IPCC 2013; HAC 2010). An independent review into the IPCC's investigation of Sean Rigg's death criticised the eight-month delay in interviewing officers fully about circumstances relating to the death, stating: 'It is difficult to understand the lack of urgency accorded by the IPCC investigation' (Casale et al. 2013: 30).

After fifty-one pages of discussion the IPCC report made two findings, which appears remarkable in the context of a 163-page investigative report. One was that the CCTV at Brixton police station was not in full working order; in fact two cameras were not working, one was in the station yard which would have covered Sean's removal from the van, the other was inside 'the cage' in which he died. The other finding was that officers 'adhered to policy and good practice' during Sean Rigg's transportation by van to Brixton police station (IPCC 2012b: 142). It went on to make two recommendations in respect of these findings. First, that the CCTV system 'should be fully reviewed'. Second, that the carriage of detainees in caged vans should be reviewed.

A Crisis of Legitimacy

The seven-week inquest produced a verdict partly based on evidence either not found or not considered by the IPCC. Consequently, there were significant disparities in the findings of the IPCC investigation report and the narrative verdict. The most apparent of these was the opening line which stated that Sean Rigg died in Brixton police station, not at King's College Hospital. Criticisms of SLaM, the CAD operators and officers from Brixton police station are not recorded in the IPCC report. The words 'fail', 'failed', 'failing' or 'failure' are recorded on ten occasions in the narrative verdict. They typically relate to actions or omissions in practice, training, communication, risk assessment and duty of care. These words barely feature in the IPCC report. In the jury verdict, the phrase 'more than minimally contributed [to the death of Sean Rigg]' is recorded on three occasions. This did not appear in the IPCC report. The penultimate line of the jury verdict stated:

> 'While Sean Rigg was in custody the Police failed to uphold his basic rights and omitted to deliver the appropriate care.'

The investigation into the death of Sean Rigg represented a crisis of legitimacy for the IPCC. The great disparity between the IPCC investigation report and the jury verdict led Anne Owers, appointed chair

of the IPCC in February 2012, to announce that an unprecedented independent review (chaired by Dr Silvia Casale) would be set up to re-examine and critically evaluate the IPCC investigation into Sean Rigg's death in light of the findings from the coronial inquest. Thus, the organisation statutorily founded to independently hold police accountable for their actions decided to refer itself to another independent entity in order to evaluate its processes. The IPCC took this reactive decision because another regulator in the form of the coronial system had uncovered a number of findings and conclusions in Sean's death that the IPCC had either overlooked, not looked for, or simply did not use in their independent investigation report. While the IPCC took four years to publish its investigation report, Silvia Casale was able to publish her report within six months, and the jury inquest in the coroner's court took seven weeks. This book will demonstrate that the content of findings in accountability construction is largely determined by the type of forum that considers the evidence, and the parameters of inquiry and investigation that exist within such a forum. It argues that this is one manifestation of a non-systematised 'system' of police regulation in cases of DAPC.

The death of Sean Rigg is not an isolated case. The book will demonstrate that Sean's death is representative of many cases of DAPC: in terms of the events that led to his death, the way in which the death was investigated, and the type of accountability which is constructed in the aftermath of the death. How can the two organisations tasked with holding police accountable in cases of DAPC produce such wildly different findings? What does this say about the way in which accountability is constructed in these cases, and about the type of police accountability that society and the state accepts or expects in England and Wales? This book examines the processes and mechanisms by which such findings are recorded and demonstrates that the type of forum that produces accountability dictates, to a large extent, the type of accountability that is constructed. It also considers the wider issue of why two different organisations are tasked with investigating and reporting on such deaths and what this might say about the state, police and society in the twenty-first century.

Death After Police Contact in England and Wales

Between 2004 and 2015 a total of 1,539 people in England and Wales died after contact with the police (IPCC 2015). The term 'death after police contact' is used throughout this book. This term adopts criteria used by the Independent Police Complaints Commission (IPCC) in regard to 'deaths during or following police contact' as stated in their annual statistical analyses on this issue (see, for example IPCC 2015). It covers the following categories stated by the IPCC: road traffic fatalities, fatal shootings, deaths in, or following police custody, apparent suicides following police custody, and other deaths following police contact (IPCC 2012a: 1).

It is rare that police officers are subject to a criminal trial in cases of DAPC, and extremely rare for them to be prosecuted as a result. Yet the state is legally obliged under Article 2 of the European Convention on Human Rights (ECHR) to investigate cases of DAPC using an independent forum. Each case of DAPC in England and Wales is typically investigated by two independent organisations (the IPCC and the coronial system) and police are held to account for their actions. This book examines how accountability is constructed in cases of DAPC in England and Wales. It argues that there is little overview of the system of accountability construction in cases of DAPC: regulation of these deaths is relatively unregulated. Thus there is limited evidence of lessons being learned to prevent future deaths. While there are processes of regulation that aim to hold police to account in these cases, regulation depends upon a wide range of contexts and factors, and tends to produce relatively arbitrary outcomes.

There is no official denial of the real and symbolic importance of cases of DAPC to society. The capacity of the state and society to hold police to account in these cases is seen as a touchstone for legitimate, transparent and consensual policing in England and Wales. Similarly, there is no official denial that deaths in state custody are significant because the state bears a unique responsibility for the welfare of citizens in their care, and a death in custody can often be viewed with suspicion by the public. Moreover, there is no official denial that a disproportionate number of

citizens from marginalised groups in society die in these cases. If you are from a Black and Minority Ethnic (BME) group, have mental health issues, or are dependent on substances then there is a disproportionately large chance that you might die after police contact. None of these issues are disputed by the state. It has made numerous official pronouncements stating how important lesson learning is in reducing the number of deaths after police contact (see, for example Fulton 2008; HAC 2010; JCHR 2004). The central issues are that lessons are not learned, the number of deaths has not reduced, and the level of disproportionality remains stubbornly unchanged. This book examines how this state of affairs continues to exist given that the subject of DAPC is so important to the real, perceived and symbolic relationships between the state, police and society. The death of Sean Rigg in Brixton police station exemplifies many of these issues.

Cases of DAPC in England and Wales are typically investigated by the coronial system and the IPCC.[2] When a person dies after police contact the case is immediately handed over to the relevant force's Professional Standards Department (PSD).[3] The PSD then refers the case to the IPCC who make a decision as to how the case is to be investigated. In Sean Rigg's case, the IPCC decided to undertake an independent investigation into his death; the investigation was undertaken and overseen entirely by IPCC personnel. The IPCC examines the scene of the death, gathers evidence and interviews relevant witnesses. When the investigation is complete a report is constructed which details how events unfolded up to and after the death; it typically includes areas which could be learned from in addition to praise for examples of best practice. Once the IPCC investigation report is concluded the death is then investigated in the coroner's court. This is typically conducted before a jury in public.

The coroner's inquest is inquisitorial, it is a fact-finding exercise and thus not able to ascribe guilt or liability. Inquests aim to examine unexplained and suspicious deaths in order to learn lessons to prevent future deaths. The inquest is able to call witnesses it deems relevant to the case,

[2] One example of an exception is the death of Azelle Rodney, shot dead by MPS undercover officers. This case was investigated by judicial inquiry (Holland 2013).

[3] The Metropolitan Police Service (MPS) is an exception, their equivalent unit is called 'The Directorate of Professional Standards' (DPS).