Dying for Justice

Edited by
Harmit Athwal
and **Jenny Bourne**

INSTITUTE OF RACE RELATIONS

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Notes and acknowledgements
Chapters 1-5 have been written by Harmit Athwal, Jenny Bourne and Frances Webber. Other sections have been written by the authors indicated on each piece.

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Vigil for Mikey Powell in September 2012. (© Ken Fero/Migrant Media)

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Abbreviations/glossary

ACPO	Association of Chief Police Officers
BME	BME refers here to Black and minority ethnic communities.
CI	Chief Inspector of Prisons/Constabulary etc
CPS	Crown Prosecution Service
DCO	Detention Custody Officer
DPP	Director of Public Prosecutions
FNP	Foreign National Prisoner
HMIC	HM Inspectorate of Constabulary
HMIP	HM Inspectorate of Prisons
IAP	Independent Advisory Panel on Deaths in Custody
INQUEST	The charity that provides a specialist, comprehensive advice service to the bereaved, lawyers, other advice and support agencies, the media, MPs and the wider public in England and Wales on contentious deaths and their investigation.
IPCC	Independent Police Complaints Commission (established by the Police Reform Act 2002) which became operational in April 2004.
IRC	Immigration Removal Centre
NOMS	National Offender Management Service
PCA	Police Complaints Authority (forerunner to the IPCC) established in April 1985.
PPO	Prisons and Probation Ombudsman
RIPA	Regulation of Investigatory Powers Act 2000
Rule 43	A report for further action issued by a coroner following an inquest.
UFFC	United Families and Friends Campaign
UKBA	UK Border Agency (set up by the Home Office in 2008, replacing the Borders and Immigration Agency, to deal with immigration, abolished 2013).
YOI	Young Offender Institution

Foreword

Colin Prescod

Colin Prescod is Chair of the Institute of Race Relations.

First you are wronged, and then you are wrong-footed. The processes and procedures for getting justice are all smoke-and-mirrors, particularly for those families, friends and communities devastated by custody death loss and then made to suffer no-answers grief with no one held accountable. And each loss is lasting. These things mark people and mark whole families, generation unto generation. For some, malaise and madness infect their every day.

Now and then a courageous and tenacious campaign exposing malpractice gets a kind of result. In 2004, for example, as a direct result of campaigning protest after Gareth Myatt, aged 15, died in Rainsbrook Secure Training Centre, the restraining 'seated double embrace position' was withdrawn from use in juvenile custody. In such rare instances the state itself effectively declares its own practices and inquest procedures as not fit for purpose – not fit, our policing; not fit, our prisons; not fit, our detention system.

In the main, official inquiries and inspections, however critical, appear to be swept by the authorities under deep-pile carpets. Another strategy is to let the state off altogether by farming out custodial duties to multinational companies – another dark glass blocking transparency, another set of procedures masking accountability.

But the wronged will not rest – the families' movement, in particular, will not go away. Their cry goes up from the streets: there must be an end to dying for justice.

1 | Introduction

Black deaths do not have a good press, especially when they occur in the custody of our custodians. The media leads the public to believe that our guardians can do no wrong. Racism leads them to believe that blacks can do no right. The silence of the custodial system is compounded by the silences of racism.
A. Sivanandan (1991)[1]

TWENTY-THREE YEARS AGO, the Institute of Race Relations (IRR) broke that silence with the publication of *Deadly Silence: black deaths in custody* which was the first account of seventy-five such deaths based on our monitoring during the 1970s and '80s.[2] Since then at least 509 people (an average of twenty-two per year) from BME, refugee and migrant communities have died in suspicious circumstances in which the police, prison authorities or immigration detention officers have been implicated. A large proportion of these deaths have involved undue force and many more a culpable lack of care. Although inquest juries have delivered verdicts of unlawful killing in at least twelve cases, no one has been convicted for their part in these deaths over the two and a half decades. Worse, despite narrative verdicts warning of dangerous procedures and the proliferation of guidelines, lessons are not being learnt: people die in similar ways year on year.

Looking back over almost two and a half decades, much has changed, while much has also stayed the same. Then, it was hard to get information on deaths: one was scouring black community papers for details, poring over notes in the newly-formed INQUEST[3] organisation's cramped office, reading between the lines of the scant number of 'official' inquiries and bland parliamentary answers to questions from the few committed MPs. Now, such deaths make the papers – the local ones at least. And at controversial inquests, the national press actually have a correspondent *in situ*. One can make Freedom of Information requests (FOIs), coroners can be corresponded with. There is an official Independent Advisory Panel on Deaths in Custody as part of the Ministerial Council on Deaths in Custody, and the Independent Police Complaints Commission (IPCC), set up in 2004 to replace the Police Complaints Authority (PCA), investigates deaths and publishes reports on these deaths. The Prisons and Probation Ombudsman (PPO) investigates all incidents involving fatalities in prisons and immigration removal centres (IRCs), and every death involving police officers must be referred to the IPCC.

Little of this would have happened were it not for the systematic and consistent campaigning of bereaved families. Though the families of those killed in the Marchioness and Hillsborough disasters[4] made the front pages of the papers, there have been hundreds of other families fighting to call the state to account for the way in which their loved ones died. And the majority of these have been from BME communities. The charity INQUEST has invariably provided advice and support and in 1997 these black family campaigns linked together to form the United Families and Friends Campaign[5] (which, also, later included white families). (See Chapter 6)

For as we stated above, in some ways deaths still follow patterns established in earlier years. Black men, especially young black men, acting erratically or even asking for help, are stereotyped first and foremost as bad, mad, and, being black, likely to be involved in drugs and/or violent – so they are met with violence.

Despite the finding of institutional racism in the police force in the landmark 1999 Macpherson Report,[6] and the implementation of many of his recommendations, including the extending of anti-discrimination law to government agencies, black people, especially young men, are still massively over-represented in stop and search (five times more likely than white people)[7] and almost three times more likely than whites to face arrest. The organisation Joint Enterprise: Not Guilty by Association (JENGbA) which works with families of those convicted under a catchall clause often used against 'gangs', states that almost 80 per cent of those convicted are from BME communities.[8] The national DNA database will soon hold details of an estimated three-quarters of all young black men.[9] The supposition that young black men are going to be particularly dangerous is also borne out in the fact that according to INQUEST's figures, of fifty-four people killed in police shootings since 1990, nine were from BME communities. In two cases

we examine, black men were shot in controversial circumstances during special police operations.

But what we have found is that the stereotype of the violent and unpredictable black man has now been extended. It is not just young men of Caribbean descent in certain deprived communities who are being prejudged as 'up to no good', or simply of no account, not deserving of courtesy and care. As we found in our research, a whole host of others are now in that category of disposability - Joy Gardner (she was an overstayer); Ibrahima Sey (he was a Gambian asylum seeker); Zahid Mubarek (he was a British Asian teenager in a young offenders' institute for a petty theft); Jimmy Mubenga (he was a foreign national prisoner).

We are not trying to assert that every officer involved in an incident with someone from a BME community, who subsequently died, harboured a particular race hatred. In fact that would be impossible to prove (although there is some evidence of prejudice in remarks made or racist jokes on phones etc).[10] But we are saying that the culture, aided and abetted by politicians and the mass media, has been impregnated over the last thirty years with views which encourage suspicion and contempt for whole groups of people who are surplus to the requirements of, or antithetical to, the neoliberal project. Asylum seekers, Muslims, overstaying migrants, the young never-employed (who may eke out a dubious living), are not just demonised daily in the tabloids as fanatics or terrorists, shirkers and scroungers but set apart by society. They are not like us, they are not part of us - in fact they are undermining 'usness'.

Poverty, unemployment, youth, colour and religion set them apart. But they are more systematically set apart by incarceration. In 1988, the prison population was 65,727, in March 2013 it was 82,869; in 1988, 17.2 per cent of that population were from BME communities, now they comprise 26.1 per cent. Without doubt, ministry of justice figures reveal that prison governors are in the words of the *Guardian* 'losing [the] fight to absorb cuts'. In the twelve months to March 2014, the prison population reached a record 85,000; serious assaults were up by 30 per cent and suicide rates rose by 69 per cent. Meanwhile the number of jails 'of official concern' has risen to twenty-eight and the number of prisoners completing programmes to tackle their criminality is down.[11] 'Mass imprisonment and organised abandonment', writes Avery Gordon, 'play a central role in ... the security-centred world economy and in its extreme and untenable social costs, one of which is our young people and their right to a future.'[12] For 'it is the poorest, most marginalised, least powerful and more vulnerable people' according to Jude McCulloch and Phil Scraton, 'who are imprisoned and detained in disproportionate numbers...'[13]

Neoliberal policies at home have of course been going hand in hand with globalisation. And it is the ravages of that system – extracting fuels and riches, seizing land and seas for agri-business and trawling, fomenting wars, striving for ever larger markets - that has so accentuated the division of the world into the haves and have-nots and set the desperate on routes to the affluent North and West for freedom and livelihoods - however menial, however illicit. Yet all the main political parties in the UK have for the past thirty years been vying with one another as to which can rid the country quickest of 'bogus' asylum seekers, unwanted migrant workers and foreign national prisoners whose prison terms are spent. In order to make sure they go, it means locating them and locking them up. A whole industry of detention and removal – what Liz Fekete termed 'The deportation machine' has been set up.[14] We have in fact a type of state of exception, a parallel detention system for this category of the unwanted – the vast majority of whom are non-white, 'foreign', rightless.[15]

Incarceration is now part of global business. Detention centres (now termed removal centres) are part of a growth industry, now largely sub-contracted to the private sector (as are an increasing number of prisons) where huge multinational companies such as G4S, Serco, GEO, Mitie order the lives and oversee the deaths of prisoners and waiting deportees. In this parallel system of detention where frightened anxious detainees often self-harm, medical care is not of the standard required of prisons (commensurate with that supplied by the NHS). The private companies have simple targets: to make sure the deportee is fit to travel and to avoid a self-harm death because that means a financial penalty for the company.

One of the most vexed issues to emerge from our research is that of accountability. As we stated at the outset, there *have* been verdicts of unlawful killing – rare though they be. But these are often contested at a higher court and sometimes reversed, or simply not followed up by prosecution, and inevitably no one is found guilty of any wrongdoing. Internal discipline or punishment is either non-existent or fleeting and mild, implicated officers retire or resign before procedures have taken their course. And the privatisation of detention services has diminished accountability yet further. The chain of command is long, the responsibility for the well- or ill-being of an inmate is sub-contracted. The state has effectively distanced itself from those it has taken into custody and for whom it nominally has a duty of care.[16] It becomes harder and harder to know whom to call to account. Now at any inquest one can find a whole phalanx of lawyers on the one side: representing perhaps the Home Office, a private company providing custodial care, a healthcare provider, an individual doctor. On 'the other side' (though theoretically there are no sides

in a coroner's court, which is inquisitorial rather than adversarial) is the family of the bereaved, sometimes without legal aid and representation only as groups like INQUEST can assist with.

But just as the victims of custody deaths have changed over the years, the state, too, has changed its processes and procedures. In 1986, following growing discontent about bias in the police, the prosecuting function was removed from the police and a separate, supposedly more objective and independent Crown Prosecution Service established with responsibility for charging and prosecution. But there has still been a marked reluctance to prosecute those implicated in unlawful killings at inquests. In April 2004 the IPCC replaced the PCA - supposedly as a more independent body, but it is still accused of not being sufficiently independent of the police, and of being weak in its power and reluctant to face up to police misconduct. They are still considered by most families to be part of the problem not part of the solution.

◆

Of the 509 cases of BME[17] deaths in custody in suspicious circumstances that we have examined between 1991 and 2014, the majority, 348 took place in prison, 137 in police custody and twenty-four in the immigration detention estate. One in three of the total deaths were as a result of self-harm and in sixty-four cases the person was known to have mental health problems. Medical neglect was a contributory factor in forty-nine cases and in forty-eight the use of force appears to have contributed to a person's death. It is not our intention here to compare BME and white death rates or to assert that BME victims are the only ones. White working-class victims of state brutality and neglect, and their families, also feel the contempt and lack of care of a system to which they are of no account. Rather it is to flag up the processes – which run from austerity measures and media portrayal to diehard closing of ranks and blatant cover-ups – through which a death takes place with impunity. How BME people are treated is in fact the litmus test of the whole system.

◆

We examine in three chapters below, using details from cases, the patterns of deaths in police custody, in prisons and in the immigration detention estate. We go on to examine the experience of victims' families after death, first with the inquest and then attempts to obtain redress and closure. The final section gives voice to those involved in deaths in custody from the point of view of the law, the community, the family and the media.

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References

1. This is excerpted from 'One death is a death too many', the introduction to *Deadly Silence* (1991) which is reprinted here as Appendix II.
2. A young man came to our offices after making a visit to a south London prison, where he said an unclaimed black man's body lay in the prison morgue. 'Who', he asked, 'is monitoring such deaths? Is it something you should do?'
3. INQUEST was set up as a consequence of campaigning by (inter alia) the widow of Blair Peach, killed by police at a Southall demonstration in 1979. Seeking answers on his death they were shocked at the way information was withheld and secrecy maintained by state authorities.
4. In 1989 *The Marchioness*, a pleasure boat, capsized on the river Thames, killing fifty-one people, and ninety-six Liverpool football fans died during a crush at Sheffield's Hillsborough stadium.
5. See Appendix III on page 82 for details of how United Families and Friends Campaign can be contacted.
6. *The Stephen Lawrence Inquiry: report of an inquiry by Sir William Macpherson of Cluny* (London, Home Office, 1999) CM 4262.
7. See <http://www.stop-watch.org/>.
8. See <http://www.jointenterprise.co>.
9. Home Affairs Select Committee, *Nature and Extent of Young Black People's Overrepresentation,* (2007). <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhaff/181/18105.htm>
10. CCTV footage of the death of Christopher Alder, on the floor of a Hull police station, revealed officers making monkey noises. It also emerged that numerous racist texts were found on the mobile phones of escort officers involved in the death of Jimmy Mubenga.
11. See Alan Travis, 'Prisons struggle with rising level of violence as suicides hit 9-year high', *Guardian* (1 August 2014).
12. See Avery Gordon, 'Abu Ghraib: imprisonment and the war on terror', *Race & Class* (Vol. 48, no 1, 2006).
13. Jude McCulloch and Phil Scraton, ' An introduction', in *The Violence of incarceration* (London, Routledge, 2007).
14. Liz Fekete, *The Deportation Machine* (London, IRR, 2005).
15. See Frances Webber, *Borderline Justice: the fight for refugee and migrant rights* (London, Pluto Press, 2012).
16. In *Globalization and Borders* (London, Palgrave Macmillan, 2011), Leanne Weber and Sharon Pickering draw on the work of Stanley Cohen to explain how governments (and their willing media allies) can control the representation of unpalatable events and withstand even the most authoritative allegations of human rights abuse by 'distanciation', in which complex chains of responsibility make it difficult to connect cause (i.e., government policies) with effect (i.e., border-related deaths).
17. This figure includes BME nationals and non-nationals, refugees, asylum seekers and migrants, who all face similar experiences in custody or immigration detention.

2 | Deaths in police custody

TWO EMBLEMATIC DEATHS – the fatal shooting by police of 29-year-old Tottenham resident Mark Duggan during a police operation led by the Trident unit, which led to the August 2011 riots in several cities, and ex-paratrooper and trainee computer programmer Christopher Alder dying on the floor of Hull's Queen's Road police station as officers stood around him laughing and joking – form the ends of the spectrum of the deaths of black people at the hands of police, a continuum with deliberate, lethal force at one end, and lack of care for injured or vulnerable people at the other.

Although the statistics from various sources differ, there is no doubt that a disproportionate number of people from BME communities die in police custody or following police contact, particularly in incidents involving force or other forms of coercion. The Independent Police Complaints Commission (IPCC) found that of the 333 people who died in or following police custody[1] over the ten years from 1998-9 to 2008-9, 15 per cent were from BME communities. Over a third of these black deaths occurred in circumstances 'where police action may have been a factor' – a proportion rising to almost half if cases of 'accidental death where police were present' are added.[2] INQUEST's statistics, covering the period 2002-2012, are even more striking: of 380 deaths in police custody in England and Wales or as a result of contact with the police, 69 were from BME communities – 18 per cent[3]

What we want to do below is show how such deaths can take place in police custody, through the stereotyping of BME individuals as violent, dangerous and unpredictable which leads to an escalation of violence and a resort to dangerous techniques, involving weaponry (batons, sprays and guns) and outlawed or unauthorised restraint methods. Similar stereotypes – and the added assumption that dying suspects are feigning distress – are behind many fatal failures of care in custody. On a basic level, all such deaths result from a lack of care, an attitude which ranges from brutality to indifference, but which reveals contempt for the dignity, well-being and lives of people deemed worthless.

Use of force

The use of force leading to a death can take many forms - from the use of dangerous holds, the shackling and reckless positioning of an individual (more likely to take place in confined places such as cells or vans) to the use of weapons such as batons and chemical restraint like CS or pepper spray and sedatives (especially in psychiatric custody) and shootings by armed police. Sometimes a number of factors are in play together, so that drawing a line, and attributing death to one particular cause, is hard. The use of undue force has been a feature in numerous controversial BME deaths in police custody. Our own figures looking at 137 deaths between 1991 and 2014 reveal that force or other form of restraint contributed to the deaths in police custody or in contact with the police of least thirty-nine BME individuals.

There are of course guidelines and training in the police service as to when and how force can be used. As the Association of Chief Police Officers (ACPO) points out in its 'safer detention' guidelines, 'The three main powers relating to the use of force are contained within: Common Law; Section 3 of the Criminal Law Act 1967; and Section 117 of PACE [Police and Criminal Evidence Act 1984] ... Responsibility for the use of force rests with the police officer exercising that force. Officers must be able to show that the use of force was lawful, proportionate and necessary in the circumstances.'[4] But in many of the cases we examined, these guidelines were breached: force was not proportionate, it was not used as a last resort and it continued even after there was no possibility of resistance. Guidelines introduced following concerns over one death are not being applied, leading to other similar deaths. And all that seems to happen is that guidelines are re-issued or refined.

Shooting to kill

The most controversial and potentially 'final' use of force is when firearms officers use live ammunition – especially because the British take pride in their policing by consent and the fact that their officers

are, unlike say the US, unarmed and therefore not trigger-happy.

According to INQUEST's figures, fifty-four people have lost their lives in police shootings since 1990, of whom nine were from BME communities – ie, they account for one-sixth of all such deaths. In two of the three cases set out below, bullets were fired in rapid succession at the head, raising questions of shoot-to-kill practices.

In the wake of **Azelle Rodney**'s death, police sought to justify their actions as self-defence in the face of an ultra-dangerous criminal. Azelle Rodney (24) was shot dead in April 2005 in north London in an operation whose details police insisted had to remain secret under the Regulation of Investigatory Powers Act (RIPA), causing the collapse of the inquest into his death.[5] Rodney, who was unarmed, had been shot six times – in the arm, the back and four times in the head – within two seconds of the police ramming the vehicle in which he was travelling. His body was then left on the pavement for sixteen hours (see also Chapter 6).

After the shooting of **Jean Charles de Menezes** in the wake of the London bombings in July 2005, it was revealed that armed response officers had been trained in secret, controversial new tactics, devised following 9/11 by a working party formed to look into ways to respond specifically to suicide bombers, involving senior police officers, representatives from Special Forces, the Ministry of Defence, law officers, Home Office officials and members of MI5. Members visited Israel, Russia and Sri Lanka, to consult with security forces there.[6] The guidelines and policies it produced were not subject to scrutiny in the public domain and it was described by an unnamed insider as 'real seat-of-the-pants stuff ... making it up as we went along'.[7]

The new protocols, approved by the ACPO and operational in January 2003, had two variants: Operation C (Clydesdale) for pre-planned operations, and Kratos for unplanned, spontaneously unfolding scenarios. They rested on a military-style logic, undermining traditional policies on the use of reasonable force. The most contentious of the Kratos guidelines was their advice to shoot at the head, rather than the chest, as shooting at the chest 'could detonate a device'. Met police chiefs denied that this amounted to a 'shoot-to-kill' policy, but the aim of

22/07/05 JEAN CHARLES DE MENEZES (27)

At 9.33am on 22 July 2005, Jean Charles de Menezes, a 27-year-old Brazilian electrician, left his home on Scotia Road, in Tulse Hill, south London to travel to work. Unknown to him, the address (with several flats and a communal door) was under surveillance by officers from Special Branch (SO12). Earlier that morning the police had found a gym card belonging to Hussein Osman, suspected of involvement in a failed suicide bomb attack the previous day, that linked him to the Scotia Road address. The surveillance officer, filming people leaving, was 'relieving himself' when de Menezes left, and missed him[8] – so no one in the surveillance team knew for certain whether the man under surveillance matched the man in the gym card photo. They followed de Menezes as he boarded a bus (not challenging him despite an order by the Designated Senior Officer in charge of the operation Cressida Dick, that he should not be allowed to enter the transport system), tracking him as he got off at Brixton station, which was shut, and got back on the bus. De Menezes got off the bus at Stockwell tube, picked up a newspaper as he entered the station, and went through the ticket barriers. As surveillance officers followed him down the escalator, he started to run for the waiting train. Two minutes later, CO19 officers ran into the station. A surveillance officer put his foot in the train doors to prevent them closing, and shouted to four firearms officers on the platform, 'He's here'. He grabbed de Menezes, pinning his arms against his side and drove him back into his seat as the firearms officers ran into the train.[9] De Menezes was shot five times in the head, once in the shoulder and once in the neck, dying instantly.[10]

Met police commissioner Ian Blair initially refused to refer the killing to the IPCC (a legal requirement), although it was referred three days later. Meanwhile, as witnesses described a man wearing bulky clothing and jumping a ticket barrier to the media teams arriving at Stockwell (probably confusing de Menezes with one of the officers following him), police compounded the misinformation by maintaining that he was a suspected terrorist. Ian Blair told a press conference that he understood de Menezes had been challenged and refused to obey police orders to stop. The following day, the *Sun* ran a front-page headline 'One down, two to go'. Following the family's complaint that senior officers had deliberately misled them and the public, an IPCC investigation, published over two years later in August 2007 (it had been delayed by threats of legal challenges from the Met), absolved Blair but questioned the failure to keep him informed, and blamed Assistant Commissioner Andy Hayman for putting out misleading information. It found that even after de Menezes' wallet and phone had been recovered and examined in the afternoon of 22 July, senior officers were briefing journalists on a connection between the dead man and the failed bombing attempt.[11]

The IPCC began its investigation into the shooting on 27 July, and in January 2006 sent its findings to the Crown Prosecution Service (CPS), which in July 2006 announced that no police officers would be charged but that the Metropolitan police would be charged for breaches of health and safety legislation.[12] The case against the Met, held at the Old Bailey, was the first time the Health and Safety at Work Act 1974 had been used to prosecute the police and was seen as a 'test case' for policing operations.[13] The inquest, postponed until after the trial,[14] resulted in an open verdict in December 2008, the jury rejecting 'lawful killing' and finding that officers had not shouted a warning before opening fire.[15]

04/08/11 MARK DUGGAN (29)

Mark Duggan was in a minicab on Ferry Lane in Tottenham, north London, when officers in three cars performed a 'hard stop' on the cab (a planned operation that involves armed officers intercepting a vehicle in order to confront suspects). Duggan got out of the car and onto the pavement, at which point he was shot twice - in the right arm, causing a minor wound, and fatally, in the chest. Following the shooting, a pistol wrapped in a sock was recovered from a grassed area over a wall, around four metres away. The police marksman who fired the shots, identified only as V53, claimed that he fired in self-defence, and at the inquest,[16] described in detail the gun, barrel and sock that he saw raised towards him ready to shoot. However, the testimony of other witnesses contradicted this, and there was no forensic evidence to suggest that Mark Duggan had ever held the gun. A shoebox was recovered from the minicab, which it was suggested had contained the gun. There was fingerprint evidence that Duggan had handled the box, but no forensic evidence linking the gun and sock to the box, or to Mark Duggan himself. Of the two civilian witnesses to the shooting, one said he saw what was 'definitely a phone' in Mark Duggan's hand. He described seeing him look 'baffled', with his hands up in the air as if surrendering, attempting to run, with the shiny Blackberry in his right hand. The other witness was the taxi driver, who said he did not see Mark Duggan open or close the shoebox during the journey, had a good view of him when he left the minicab and did not see him with anything in his hands, raising his arm or making any threatening movements towards the police.[17]

At the inquest, much was made by the Trident officers of Duggan's alleged crimes and his being a 'senior' member of the Tottenham Man Dem (TMD) 'gang' – although he had never spent time in prison and his criminal record consisted of two minor convictions, for receiving stolen goods and possession of cannabis, and nothing since 2007.

The inquest verdict, delivered in January 2014, caused dismay. Although all ten jurors agreed that there had been a gun in the taxi with Duggan, eight disbelieved the evidence of the police marksman who shot him, and were sure he was not holding a gun when he was shot dead. But by an 8-2 majority, they concluded that he had been lawfully killed. They believed that he must have thrown the gun from the taxi before it was surrounded, an idea unsupported by any evidence. In March 2014, the High Court gave the family permission to challenge the verdict. At the July hearing, lawyers argued that the coroner's directions were confusing. Meanwhile the coroner issued a Rule 43 report[18] which was critical of the officers for writing their notes of the incident together, giving the impression of collusion.

The IPCC's investigation into the shooting is still ongoing, although in a separate investigation, the family's complaint of its treatment by police and by the IPCC itself was upheld.[19]

immediate incapacitation by a head shot made death practically inevitable. The guidelines also advocated repeated, multiple shots at close range to achieve rapid incapacitation, while standard ACPO guidance discouraged secondary or 'additional' shots, on the basis that each and every shot was subject to the same legal test: it was only to be used to counter an immediate threat to life.

The Kratos guidelines provided for a Designated Senior Officer (DSO), who, with access to intelligence perhaps unknown to officers on the ground, could authorise a critical shot at a suspected suicide bomber by means of a code word, marking a significant break from the established legal basis for the use of force, which rested on an individual police officer taking responsibility for the decision to shoot on the basis of his or her assessment of the threat. The use of DSOs removed this individual responsibility from the firearms officer, moving it up the chain of command. In effect, officers were asked to act in a way that was more akin to following a military order than the exercise of their own independent judgement as a constable.

De Menezes' killing was the result of reckless mistakes – of identification, of interpretation and of action, in a climate of heightened fear after the 7/7 and 21/7 suicide-bomb attacks on public transport. No fear of suicide bombers marked the shooting dead on a London street of **Mark Duggan** in August 2011, no mistaken identity – just the usual stereotypes of black criminality and dangerousness. The operation was run by Trident, a Met police unit specialising in gun crime within London's black community. The death, and the subsequent treatment of his family, triggered riots in London, which spread to other inner-city areas, over several days.

'Non-lethal' weapons

Firearms are, of course, meant to be used only in situations where lives are at risk. But police forces are always looking for more powerful alternatives to truncheons to protect officers from assault while on duty, and since the early 1990s, new weaponry for control and restraint - long American-style side batons and chemical sprays - have been introduced into the Metropolitan police and later, other forces. They have been used with reckless abandon and in breach of strict guidelines in several cases where black men were casualties.[20]

Batons

In 1992, the Police Federation called for the issue of American side-handled batons to officers in the UK. The controversy caused by the beating of Rodney King with the side-handled baton led the home secretary to refuse UK trials, so police

08/05/95 BRIAN DOUGLAS (33)

Douglas, a boxing promoter, was pulled over for driving erratically, and was hit on the head during his arrest with a US-style 22-inch baton. He sustained a fractured skull and irreversible brain damage. He was not taken to hospital but to Kennington police station, where he was diagnosed four times as being drunk or drugged. Only when his face became paralysed and his speech slurred later that day, was he taken to hospital, where he died. In April 1996, the CPS decided there was insufficient evidence to prosecute the officers involved. An arresting officer told the inquest in July 1996 that the blow was aimed at Douglas's upper arm but had slid upwards to hit his neck. Other eyewitnesses said they had seen a downward blow. Three pathologists found that the fatal blow had been to the back of the right side of the head. The jury recorded a verdict of death by misadventure. The coroner called for more training in the baton's use and better recognition of illness or injury in police custody.[22]

In October 1996, the Police Complaints Authority (the forerunner to the IPCC) announced that the officers involved would not face disciplinary charges, and in March 1997, the High Court ruled that there was 'no sound basis in law for ordering a fresh inquest,' although the evidence of the two officers involved was deemed 'by no means wholly satisfactory'.

forces began trialling other types of baton, some rigid and some expandable, but all longer than the standard truncheon. A scientific evaluation led to a recommendation that the expandable side-handled baton be allowed as an alternative to the truncheon.[21] In November 1994, 20,000 Metropolitan officers were issued with 22-, 24- and 26-inch acrylic US-style batons. **Brian Douglas**, a black man, was killed seven months later. Douglas' death in 1995 became a highly controversial case as his family tried to raise issues over use of force and lack of accountability.

CS gas

CS gas (also known as tear gas) had been developed in Britain since the 1940s and was used against rioters in Derry in 1969 and in Toxteth, Liverpool in 1981. But it was only in March 1996 that police officers were issued with personal spray canisters, in a six-month trial. Two weeks into the trial, **Ibrahima Sey** became the first fatal casualty, doused with CS spray while handcuffed and on his knees in a police station yard.

Sey's death did not appear to inhibit the use of CS and other sprays. Although Surrey and Hertfordshire police withdrew from the trials and other forces declined to use it because of concerns for officers' safety, the home secretary approved the general issue of CS spray in August 1996. ACPO also approved the spray. Serious concerns about the medical effects of being sprayed[24] led in 2001 to a request by the

16/03/96 IBRAHIMA SEY (29)

Police officers were called to the home of Ibrahima Sey, a Gambian asylum seeker with a history of mental health issues, after a domestic disturbance on 16 March 1996. Sey was taken, unresisting, to Ilford police station, accompanied by a family friend, Pa Ndimbalan. At the station, Sey, by now handcuffed, was begging officers to allow his friend to come with him when he was pushed to the ground - the last time his friend saw him alive. It transpired at the inquest that, on his knees in the secure rear yard of the station, surrounded by over twelve police officers, he had CS sprayed into his mouth, eyes and nose at a distance of four to five feet. Then he was taken into the station where he was restrained face down on the floor, with hands cuffed behind his back, for over fifteen minutes, until he died. He was still handcuffed, though completely still, when the ambulance arrived. He was pronounced dead at 6.23am at King George's Hospital, one and a half hours after his arrest. Post-mortems carried out by pathologists representing the coroner, the Metropolitan police and the Police Federation concluded that Sey died 'following a period of exertion and was suffering hypertensive heart disease' and that 'there was no evidence that the CS spray contributed in any way to his death'. At the inquest in October 1997, the official explanation was revised: his sudden death was a result of 'acute exhaustive mania' because of his mental illness. (Toxicology tests showed that there were no drugs or alcohol in his body.)

The post-mortem carried out for Sey's family found a different cause of death - positional asphyxia (from restraint face-down, see below), with contributing factors including exhaustion due to his mental illness and CS spray. Police guidelines on the use of CS spray state that it should be used in self-defence or when dealing with subjects who cannot be restrained, and that those who have been sprayed 'must not be left in or transported in a prone position'. After a four-week inquest, the jury recorded that he was killed unlawfully through an act of gross negligence and died through 'postural asphyxia and excited delirium'.[23]

In October 1998 the CPS decided that there was 'insufficient evidence to justify proceedings against any police officer'.

Home Office's Police Scientific Development Branch to scientists at Porton Down, the Ministry of Defence laboratory, to find an alternative to CS, but it is still in use. In November 2004 the Home Office also agreed to support the use of PAVA (pepper spray), which is more potent. Both sprays have a range of four metres, and forces can decide which to use.[25]

Of the 333 deaths in the IPCC report,[26] batons and CS/PAVA spray were each used in twelve cases, and their use has contributed to several BME police-related deaths.

- **Peter San Pedro** (25) died in April 1997 by walking into the path of a lorry hours after being sprayed by police in Kent.
- **Michael ('Mikey') Powell** (see below), arrested in

September 2003, was hit by a police car, sprayed with CS gas and restrained with a baton in Birmingham.

- **Frank Ogboru**, a Nigerian tourist, was sprayed during an altercation with police in September 2006 in Woolwich, London.
- **Nadeem Khan** died in June 2007 after being sprayed twice and restrained by five police officers called to reports of a man damaging property in Burnley. An inquest jury found he was suffering from 'excited delirium' which had not been recognised.
- **Ayodeji Awogboro** was sprayed by police as he tried to flee following a driving offence in Islington in May 2008.
- **Jacob Michael** was sprayed in the face with pepper spray as he was arrested by eleven officers in Cheshire in August 2011.

Physical restraint

Some of the most controversial deaths are those where physical force has been used during restraint, raising questions of whether the force was reasonable and proportionate. Although restraint causes few deaths numerically, it disproportionately affects BME individuals. According to INQUEST, in the eleven years 1995-2005, one-third of restraint-related deaths in police custody (twenty-three out of sixty-nine) were of BME individuals.[27] Another study of deaths from 1999-2009 found that 68 per cent of restraint-related state custody deaths took place in police custody, and of these twenty-two deaths, eight were BME.[28] As the IPCC states: 'people from BME groups were significantly more likely to be restrained than White people.'

Such cases begin with a supposition by officers that the individual is either up to no good and/or will possibly present problems. In other words they cease to see the person and see only a problem – someone who is shouting on the street, an illegal immigrant, someone involved in drugs. Often an inordinate number of officers are employed, which itself creates a reaction, when additional force and unnecessary aids such as handcuffs or tape are added to a chaotic altercation (as with Joy Gardner: see Chapter 4). Dangers to a suspect's health or life are disregarded in the struggle to bring him or her (usually him) under control.[29] And in many instances the victims, perceived or misread by officers as particularly dangerous or involved in crime, are suffering mental health problems, or in need of medical assistance for injuries sustained during the encounter. But officers realise too late that their charge has stopped struggling, stopped breathing or is inert. Then, medical help is called – when the person is beyond help.

Drug searches, neckholds and choking

Certain groups are particularly vulnerable to excessive restraint. Black men are very often assumed to be not only violent but also involved in drugs, and the double mis-perception can be fatal. The IPCC report on deaths in custody found that of the fifty-six drug-related cases of death in or following custody, 43 per cent had involved restraint of the individual. The most common restraint technique used in these cases involved the individual being held down by officers. They were significantly more likely to be younger (aged 18-34 years) and a higher proportion were from BME groups.

Shiji Lapite was choked to death and his body had some forty separate injuries. And yet no one was prosecuted, despite all the evidence that showed how he had been manhandled and shamefully hurt.

Other deaths during or as a result of drugs searches include **Donovan Williams**, who died in a Peckham police cell following a search in 1996 (an inquest recorded a verdict of accidental death), and **Sean Beard**, who died in 2005 when police tried to retrieve drugs from his mouth.

16/12/94 OLUWASHIJI (SHIJI) LAPITE (34)

A Nigerian asylum seeker, Lapite was stopped by Stoke Newington police for 'acting suspiciously' and arrested on unspecified drugs charges – though no drugs were ever found in his possession. A struggle occurred, during which Lapite was injured. He collapsed and died after being placed in a police van. The post-mortem found that the bones in Lapite's voice-box had been broken; he died of asphyxiation, suggesting that police officers had used a 'choke-hold'. (This was the first such death to occur since advice was issued in 1993[30] on the use of choke-holds following the death of Oliver Pryce in police custody.) The Police Complaints Authority (PCA) submitted a report to the CPS, who declined to prosecute the officers because of 'insufficient evidence to provide a realistic prospect of conviction'.

According to two pathologists, Lapite's body had thirty-six or forty-five separate injuries. At the inquest, the two officers involved admitted kicking his head and biting him, but claimed that they did so in self-defence – an account unsupported by evidence of any injuries or marks on them, and doubted by the coroner. The inquest recorded a verdict of unlawful killing, and the coroner referred the case to the Director of Public Prosecutions (DPP) for possible manslaughter charges. In August 1996, the CPS again decided that there was insufficient evidence to proceed against the officers involved, and in December 1996, the PCA decided that they would not face disciplinary charges. In July 1997, the High Court quashed the decisions not to prosecute after the DPP and PCA admitted that they failed to give proper consideration to all the evidence.[31]

21/11/05 SEAN BEARD (39)

A father of five, Beard died in Burton (Staffordshire) on 21 November 2005 following his arrest by police for drink-driving. At the police station, officers carried out a strip search, during which he was seen to put something in his mouth. Two officers restrained him while another put his hand on Beard's throat in a 'blade-like motion' as an 'instinctive reaction' to stop Beard from swallowing. He was forced to the floor and handcuffed to the rear. Officers searched his mouth but were unable to retrieve anything. While he was on the floor they realised that he was unwell and commenced first aid and an ambulance was called. Paramedics removed a package from his windpipe but he died later that night in hospital. The inquest jury recorded a critical narrative verdict, finding that Beard died as a result of his airway being obstructed and adding that he should not have been handcuffed when officers believed he was choking. The IPCC found his arrest, detention and search lawful.[32]

Fifteen months after Beard's death, another young man, **Jason McPherson** (25), died after police sought to retrieve drugs from his mouth. On 18 January 2007 McPherson was stopped by police and taken to Notting Hill police station for a drugs search, during which he became unwell. An hour later he died in hospital. An inquest in February 2010 found that no excessive force was used. The narrative verdict found that he died from cocaine intoxication but was given no opportunity to remove the drugs voluntarily and that 'procedures were not appropriately implemented'. The IPCC investigation agreed that excessive force was not used.[33] But CCTV footage from inside the custody suite, featuring in the film *Po Po*, by Ken Fero,[34] shows up to twelve officers pouncing on McPherson as he sits handcuffed in the custody suite. According to his mother, he was heard to shout 'I can't breathe' as the struggle ensued.[35]

Guidance on safe (and unsafe) drugs searches, devised following inquests where recommendations were made,[36] did not prevent the death of **Habib Ullah** in 2008 in what was almost a re-run of Shiji Lapite's death.

The imperatives of policing mean that retrieving 'evidence' is seen as more important than an individual's wellbeing. The death of Habib Ullah also shows police officers (some of whom would have been first aid trained) at a loss as to what to do once he was inert and limp. This failure to respond to a person in distress features in other deaths below.

03/07/08 HABIB 'PAPS' ULLAH (39)

Habib Ullah suffered a cardiac arrest and died in hospital after being restrained by five officers during a stop and search carried out in High Wycombe on a car in which he was travelling. According to a witness in the car who gave evidence at the inquest in December 2010, when an officer accused Ullah of having something in his mouth, they tried to get Ullah's arms behind his back. One witness heard 'break his arm' and saw that they were 'trying to put their fingers in his mouth ... before they strangled him'. Ullah was hit on the back several times, then taken to the ground. The officers were 'putting their hands around his throat and pressing down' to stop him swallowing, with 'thumbs on Ullah's windpipe', kneeling on his back, holding his legs and arms down. Ullah said nothing, then went limp. The officers then 'stood around doing absolutely nothing'. Another witness described officers as 'pushing [their] thumbs up under his neck' and 'squeezing his windpipe' and using force even when 'he wasn't struggling'. 'I can't understand why they used so much force ... it was a horrific amount of force'.[37]

Police evidence was also damning. Officers admitted using 'pain compliance' techniques. One officer testified to seeing another grip Ullah's throat. Another admitted to grabbing Ullah's head with his thumb in Ullah's eye socket. Yet another thought that Ullah was being 'difficult' and 'faking injury or illness'; 'no first aid was required' as Ullah's chest was moving. The inquest was into its second week and was hearing medical evidence when it was stopped and the jury discharged. The IPCC, which had found no evidence of wrongdoing in its initial investigation, had decided to re-open the investigation, as it had emerged during the inquest that the officers had amended their witness statements.

In February 2014, the IPCC referred the case to the CPS to consider whether to bring criminal charges against five Thames Valley police officers and a Police Federation solicitor. In August 2014 the CPS declined to prosecute. The inquest reconvened on 2 February 2015.

Positional asphyxia

'The most common restraint technique' implicated in deaths in custody, the IPCC report explains, was 'being held down by police officers, used on 54 occasions during arrest and 21 occasions in custody or hospital.' Of the sixteen deaths the IPCC identified where restraint was implicated as the primary or secondary cause of death (of which a quarter were BME), a quarter were also classed as positional asphyxia.[38] Our statistics show that positional asphyxia was identified in nine cases of death in police custody.

Positional or postural asphyxia – where the body's position restricts a person's ability to breathe - became widely recognised as a cause of death in the 1990s. ACPO guidance makes clear that placing suspects in a prone position, alone or in combination with pressure on the neck, torso or abdomen, gives rise to the risk of death by positional asphyxia and that the prone position must be avoided if possible, and minimised if unavoidable. It also recommends that body weight should not be used on the upper body (ie, sitting on a suspect) to hold down a person. During transportation, 'Owing to the risks of

18/01/99 ROGER SYLVESTER (30)

An administrative officer for a drop-in mental health centre who had himself suffered from mental health problems, Roger Sylvester[40] died seven days after being restrained by police officers, who were called when he was seen naked and acting 'strangely' outside his Tottenham home. Two police officers initially attended the scene, but they called for back-up and another six officers arrived. Sylvester was restrained, handcuffed, carried to a police van and taken to the emergency psychiatric unit at St Ann's Hospital, Haringey, where up to six officers continued to restrain him (still handcuffed) for over twenty minutes. He stopped breathing, was resuscitated but fell into a coma and died seven days later in hospital without regaining consciousness.

A police investigation concentrated, according to Sylvester's mother Sheila, on Sylvester and the family, seeking to blame anyone but the police, and in 2000 the CPS decided not to prosecute anyone for the death. The inquest was held in September 2003 – over four and a half years after Sylvester's death, and again, police persistently referred to Sylvester's use of drugs, his violence and his 'exceptional strength'.[41] All of the officers involved denied holding Sylvester down on his front, although one admitted that 'I placed my right knee on his face and took control of his head'. The officers restraining Sylvester received no injuries. In contrast, post-mortem examinations showed that there was deep bruising around Sylvester's neck.

At least four pathologists and two psychiatrists gave opinions on the cause of Sylvester's death, ranging from 'excited delirium' (ED) caused by cannabis use, to lack of oxygen caused by struggling against the police restraint. The jury, preferring the latter explanation, found that Sylvester had died from brain damage and cardiac arrest and had been unlawfully killed. Although he had been lawfully detained under the Mental Health Act, 'more force was used than was reasonably necessary, causing a significant contribution to the adverse consequences of restraint'. Sylvester had been held in the restraint position too long, there was a lack of medical attention and no attempt was made to alter the position of restraint, the jury held.

After the verdict, the Metropolitan police suspended the officers involved, though they were later reinstated. The unlawful killing verdict was quashed in November 2004, the judge ruling that the coroner's summing up was inadequate and the jury confused. In June 2005, the CPS decided there was 'insufficient evidence' to bring charges against the officers.

21/08/08 SEAN RIGG (40)

Rigg died after being arrested and restrained by four police, two of them trainees, when suffering a mental health relapse.[42] Rigg, diagnosed as schizophrenic, was a talented musician who lived in a special hostel and tried to live a normal life. After missing a dose of his medication, he had a psychotic episode. The hostel called police, who failed to send a unit. Later, Rigg was arrested by four officers, two of them trainees, for assaulting a police officer and public order offences after acting erratically in the street. He was restrained and taken in a van to Brixton police station, where, after being left in the van for ten minutes, he was placed in a metal cage in the yard. Shortly after arrival, he is said to have collapsed and stopped breathing. He was pronounced dead in King's College Hospital.

In August 2012, after a seven-week inquest including legal argument and the coroner ruling out possible verdicts of 'unlawful killing' and 'neglect' riders, the jury delivered a damning narrative verdict. The jury was critical of South London and Maudsley NHS Foundation Trust for its failure 'to put in place a clear and adequate risk assessment and crisis management plan' in the light of clear signs that Rigg was relapsing, or to communicate with and involve his family. But the bulk of its criticism was reserved for the police (including civilian staff). They did not respond appropriately or in a timely manner to the calls from hostel staff; officers at the scene failed to communicate among themselves or with their command structures; an 'unsuitable' level of force was used while Rigg was restrained in a prone position for at least eight minutes. The jury questioned 'whether the relevant police guidelines or training regarding restraint and positional asphyxia were sufficient or were followed correctly' and found that Rigg 'was struggling but not violently' and that the length of restraint in the prone position was unnecessary. Police failure to recognise that Rigg was vulnerable was 'inadequate'. And for the sixteen minutes he was held in a cage at Brixton police station 'there was an absence of appropriate care and urgency of response by the police which more than minimally contributed' to his death. An attempt by officers to stand Rigg up (while unconscious) was found to be 'unacceptable and inappropriate'; keeping him handcuffed was equally inappropriate as well as unnecessary. The jury noted that: 'The views expressed by the police officers that Rigg was violent and possibly not unwell, deprived Sean of the appropriate care needed and there was a failing to secure an ambulance as quickly as possible.' Police also 'failed to uphold his basic rights and omitted to deliver the appropriate care.'[43]

positional asphyxia, the prone position should not be used. If it is unavoidable, the detainee must be constantly monitored.'

Violent restraint of mentally ill people

When it comes to restraint, it seems police still do whatever it takes to quieten someone. This applies with particular force to the treatment of those with mental health problems; a feature of many BME deaths in police custody is the failure by police staff to acknowledge and act on mental health problems so as to see individuals as in need of treatment rather than arrest. In fact, according to the IPCC, 'Approximately half of all deaths in or following police custody involve detainees with some form of mental health problems.'[39]

Two deaths at the hands of the Metropolitan police, nine years apart, show how little has changed

in the treatment of those with mental health problems. The deaths of **Roger Sylvester** in 1999 and **Sean Rigg** in 2008 both involved inappropriate restraint, compounded by other failures. Between these two deaths, we estimate that eight BME people with mental health issues died following contact with the police.

The campaign waged by the family of Sean Rigg to uncover the truth of his death has borne fruit, both in terms of the jury's verdict and the resulting actions of the oversight agencies, which should result in improvements in police treatment of those with mental health problems (see Chapter 5).

The Metropolitan police commissioned an independent review of its response to people with mental health problems, which reviewed fifty deaths and five incidents resulting in serious injuries over a five-year period, and found discriminatory attitudes, systemic and individual failures and errors, limited resources and poor coordination with other services.[44]

The month after Rigg's death, an IPCC report condemned the over-use of police cells as a 'place of safety' for those exhibiting mental distress,[45] and the disproportionate detention of black people under mental health powers.[46] A similar pattern obtained five years later.[47]

The extremely serious repercussions of presupposing a black man is dangerous rather than distressed were also seen in the process leading to the deaths of Ibrahima Sey and Michael 'Mikey' Powell. A 38-year-old father of three young children, Powell died in police custody on 7 September 2003 after suffering a psychotic episode and breaking a window, leading his mother to call the police. When he hit the police car with his belt, they drove at him, then sprayed him with CS gas, hit him with a baton and restrained him on the ground. He was held face down throughout the journey to Snow Hill police station, Birmingham and it was only when he was placed in a cell that officers realised he was not breathing. He died of positional asphyxia. Ten officers were charged with criminal offences, ranging from dangerous driving to assault and misconduct in public office, but were acquitted when the judge ruled that CCTV evidence was of too poor quality to be relied on, and the IPCC decided not to recommend disciplinary charges.[48]

There are many other black men whose sudden, unexplained death following contact with police, raises concerns about the treatment of vulnerable people. They include:

- **Olaseni Lewis** (23), a business student, died in Mayday Hospital, Croydon on 4 September 2010 after being restrained for up to forty-five minutes by eleven police officers at Bethlem Royal Hospital in Beckenham. After suffering bouts of unpredictable behaviour, Lewis had voluntarily sought help at Mayday Hospital. He was sectioned and sent to the Maudsley Hospital, and from there to the Bethlem Royal. Hours later he was back at the Mayday in a coma, on life support. He died days later. An initial IPCC investigation into the death ruled that no officer was at fault, although nurses at Bethlem Royal were allegedly horrified at the police action, which they logged as 'violent restraint'. After calls for a full inquiry by the Justice for Seni campaign, set up by Olaseni's family and friends, supported by the *Croydon Advertiser*, the IPCC reopened its investigation into possible criminal conduct by police, but police refused to cooperate, and the family was forced to get a court order quashing the first IPCC report to enable the investigation to be re-started.[49]
- **Kingsley Burrell** (29), a father of two and Birmingham University student, died on 31 March 2011 at the Queen Elizabeth Hospital, Birmingham, four days after being arrested under the Mental Health Act, although he had no history of mental illness and he called the police after being threatened in the street. He was taken to a Birmingham mental health unit where, days later, police officers responding to a 'disturbance' restrained Burrell and later took him to hospital with a cut eye. Discharged to the unit, he 'suffered a serious medical condition'[50] and was taken back to the hospital where he died. In March 2013 the IPCC arrested four police officers on suspicion of manslaughter by gross negligence and misconduct in public office,[51] and in October 2013 it passed the files to the CPS for possible prosecution. In July 2014 the CPS declined to prosecute, citing 'insufficient evidence'.[52]
- **Philmore Mills** (57), a father of three, died in police handcuffs on the floor in the local NHS acute hospital Wexham Park, Slough on 27 December 2011. He was admitted to the intensive care unit on 21 December 2011, suffering from pneumonia, and moved on Christmas Eve to a respiratory ward. In the early hours of 27 December, an incident occurred in which hospital security and then police were called. Mr Mills was handcuffed and restrained. He became unresponsive, and was pronounced dead shortly afterwards, following failed resuscitation attempts. The IPCC sent files to the CPS for possible prosecution of two officers and a civilian security guard, but in March 2014 the CPS decided no charges would be brought.[53] The family, who were told he died of a heart attack, are still waiting for an inquest to uncover the truth behind their father's death.

In February 2014, as the IPCC announced that thirty-two police officers and staff could face

01/04/98 CHRISTOPHER ALDER (37)

Father of two, trainee computer programmer and ex-paratrooper, Alder died on the floor of Hull's Queen's Road police station. After receiving a head injury during a fight at a nightclub, he was taken to Hull Royal Infirmary, where doctors claimed he was 'troublesome' and discharged him after deciding the lump on his head was not serious. He refused to leave and was arrested and taken to the station in the back of a police van. On arrival, he was unresponsive, and officers dragged him from the van by his arms, laying him face down in the charge room and not bothering to pull up his jeans, which had fallen down as they dragged him. CCTV footage of the twelve minutes Alder lay on the floor of the custody suite shows that no officer checked him or questioned him, as he lay gasping for breath, with his trousers and pants around his ankles, hands cuffed behind him. Instead five police officers stood around making comments such as: 'He is as right as rain ... this is just a show', 'He kept doing a dying swan act falling off the trolley', and even monkey noises - followed finally by, 'He's not fucking breathing lads ... do you want an ambulance'.

The post-mortem was inconclusive, suggesting that Alder had mental, drug and heart problems. But most of the seventeen pathologists eventually instructed agreed that the position he was placed in caused positional asphyxia, and although they did not agree as to whether this caused death or whether he would have died anyway, Alder was 'denied at least the chance of life'.[56]

The inquest began in July 2000 and lasted thirty-three days – then the longest hearing on a death in police custody. The five police officers declined to answer 150 potentially incriminating questions. The jury recorded a historic unanimous verdict of unlawful killing (manslaughter by gross negligence), and a police attempt to get the verdict overturned in the High Court failed. But a prosecution of the five officers for manslaughter and misconduct in public office in 2002 resulted in acquittal on the judge's direction, and the officers were cleared of misconduct by a disciplinary tribunal the following year. In March 2006 the IPCC found that four of the officers were guilty of 'the most serious neglect of duty'. The Chief Constable of Humberside police apologised to Alder's family and said that changes implemented since his death included comprehensive training for custody officers, first aid training for all police staff and the placing of a full-time qualified nurse in each of Hull's two main custody suites.[57]

charges over the deaths of six black and Asian men, home secretary Theresa May asked HM Inspector of Constabulary 'to undertake a specific thematic inspection in 2014/15 on the welfare of vulnerable people in police custody, including but not limited to, those with mental health problems and people from black and minority ethnic backgrounds'.[54]

But there does not have to be violent restraint for death to ensue. A lack of care can also kill.

11/11/96 EPHRAEM 'OSCAR' OKOYE (53)

Okoye died in hospital on 11 November 1996, five months after being arrested by police in Streatham on 14 June on suspicion of drink driving and failing to give a sample of breath. It was not until some time after his arrest that officers realised that Okoye was not drunk but seriously ill; he had suffered a brain haemorrhage. A blood sample later showed that there was no alcohol in his body at the time of his arrest. A month after his arrest Okoye regained consciousness, and although still paralysed down his left side began to make a recovery. Okoye was able to communicate by nodding and using his eyes. His wife, Ngozi, said 'when he was out of the coma I asked him what happened, I asked him questions and he nodded and made signals implying the police had beat him'. A post-mortem gave the cause of death as acute pneumonia, renal failure, brain haemorrhage and diabetes. The inquest into his death began on 23 June 1997, was adjourned after arguments over evidence, to allow the family lawyers more time to scrutinise police and medical files. In October 1997 the inquest recorded a verdict of death by natural causes.

Lack of care

The death of **Christopher Alder** in 1998 in the custody of the Humberside police demonstrates how institutional racism can prevent the appropriate care and treatment of black people who are suffering severe physical injury. His death, recorded on CCTV, is one of the most poignant, leading to an unusual unlawful killing verdict at the inquest, the prosecution of police officers and a report by the IPCC[55] which condemned four officers' 'unwitting racism' and 'lack of common decency'. These outcomes owe much to the tenacious campaign waged by Christopher's sister, Janet Alder. (See Chapter 6.)

Failing to respond to health needs

In some cases, particularly involving drugs, guidance relating to people suspected of swallowing drugs, or having drugs in their mouth, has not been followed.[58] **Leon Marshall** died in hospital on 15 July 1999 two days after being arrested for drugs-related offences in Coventry; officers were aware he had swallowed drugs but failed to take him to hospital. In other cases, like those of Christopher Alder and Sean Rigg, police assume distress is feigned, and so take no remedial action. Other stereotypes and assumptions about people who come into the custody of police, such as that they are intoxicated or under the influence of drugs, operate to prevent prompt medical assistance.

In other cases, indications that someone might be vulnerable or a suicide risk have been ignored.

30/10/09 MOHAMMED IQBAL SAFI (18)

An 18-year-old asylum seeker from Afghanistan, Safi was seen in the River Thames at around midday on 30 October, shortly after being released from police custody, although his body was not found until 18 November. He had been arrested on suspicion of overstaying and taken to Fulham police station at about 3am. Safi had a bandaged wrist and had difficulties speaking English. The custody officer recorded that he had answered 'no' to questions about recent medical treatment, self-harm or suicide attempts, and that there were no communication difficulties. But CCTV footage showed him answering 'yeah' when asked if he had been at hospital, and asked 'did you ever try to harm yourself?' he said 'yesterday.' He did not respond when asked whether he had ever attempted suicide. Pre-Release Risk Assessment forms were not completed before Safi's release by a second custody officer.

The IPCC investigation found that both custody sergeants breached professional standards by the failure to conduct or record adequate risk assessments, although it might not have made a difference. From the CCTV footage, the IPCC also found that 'some police officers and staff made disparaging remarks about Mr Safi which seemed to convey a dismissive attitude. This raises concerns about their attitude towards him and, perhaps, to others in similar circumstances.'[59]

12/11/09 JIANPING LIU (36)

A Chinese national with mental health problems, Ms Liu died after jumping from a bridge at Heathrow airport. She had been found at 1.20am wandering around the airport with a copy of her passport (with an expired UK visa), and appeared to speak limited or no English. She was arrested as a suspected overstayer/illegal immigrant and held overnight at Heathrow police station. No interpreter was called during her booking in at the police station, but a doctor, who assessed her through an interpreter, concluded that she was at risk of self-harm and wanted to return to China. In the morning, the UK Border Agency (UKBA) confirmed that she was in the UK lawfully, having been granted leave to remain (a fact not known to Ms Liu, who was waiting to hear from her solicitor). She was released from police custody, again without an interpreter being called to explain what had happened. CCTV footage showed her not appearing to understand what was being explained to her, namely that she was free to go, had been granted indefinite leave to remain and should contact her solicitor. A couple of hours later, members of the public saw Ms Liu wandering around the airport behaving oddly. They saw BAA security staff surrounding her and subjecting her to taunts and bullying. Deciding that Ms Liu was vulnerable and in distress and possibly mentally unwell, they made a complaint and requested help from the BAA information desk, but staff declined to intervene.

The inquest jury found that Ms Liu took her own life and that on the balance of probabilities the police did not carry out an adequate pre-release assessment.[60]

Conclusion

A number of areas of concern emerge from an examination of cases over time:

- A disproportionate level of force used on BME individuals by police;
- A disproportionate use of often new and untried weaponry;
- The stereotyping of individuals as violent, volatile and /or mad;
- A lack of training in potentially dangerous restraint methods;
- An over-use of police custody and restraint of mentally ill individuals;
- A failure to assess health and self-harm risks;
- A failure to apply lessons learned from earlier fatalities, resulting in similar deaths;
- A consistent failure to hold officers to account;
- A growing lack of confidence in affected families and their larger communities that justice will be done.

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very clear: 'If it is known or suspected that a detainee has swallowed or packed drugs ... the person must be treated as being in need of urgent medical attention and taken straight to the nearest hospital. Leakage from a package can prove fatal. If a package is swallowed to avoid detection, it is likely to have been prepared hastily and there is an imminent risk that it may come open or burst inside the person. If this happens, death can quickly follow, particularly when crack cocaine has been swallowed ... If the detainee has been brought to a custody suite, an ambulance must be called immediately.'

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3 | Deaths in prison custody

BETWEEN JANUARY 1991 and July 2014, there were at least 348 suspicious or controversial BME deaths in prison according to our data, of which eight could be attributed to some use of force and at least twenty-eight to a lack of care.

Numerically, more people will die in prison than in police custody, by virtue of the time they spend in prisons and the sheer number of prisoners (85,428 as at July 2014). And 25 per cent of the prison population is estimated to be from a BME background. Figures collated by INQUEST[1] reveal that of all the 3,378 deaths in prison between 1990 and 2014, 1,703 were self-inflicted, 1,555 due to natural causes, thirty-seven not natural, seven involved restraint, forty were homicides and thirty-six not yet classified. Of these, BME deaths were 399: 215 self-inflicted (a slightly higher percentage than for the overall population), 164 ascribed to natural causes (a lower percentage than for the overall population), but six of the seven restraint deaths (85 per cent) were of BME prisoners.

The IRR has examined those BME deaths in prison which appear to some extent to be suspicious and revealing of patterns of control or care which suggest that this group of prisoners face forms of direct or indirect racism. In the next chapter we examine the deaths of immigration detainees who face a different regimen. In all categories we note the involvement of private companies in custodial duties.

What is significant to flag up from the very start is, first, the need to see use of force and lack of care as points on a continuum rather than juxtaposed instances. For very often an incident which begins with a lack of care ends in the use of force. Second, classifications of deaths by state agencies have to be treated cautiously because a self-inflicted death or even a death classified as due to natural causes might also follow a lack of care by the prison authorities for the prisoner's mental or physical well-being. Third, this lack of care, which morphs into poor risk assessment, can be a significant element in a number of homicides where inmates were put at risk of attack from violent racist inmates.

It is hard to quantify deaths due to lack of care or negligence, because of the way official data is collected. There is no actual lack of care verdict at inquests, although it can be added as a rider, and narrative verdicts are often critical of the care a deceased received (ie, processes and failings in procedures that may have led to a death). But lack of care is perhaps one of the most frequent causes of a suspicious death in custody. Although it may not be as obvious or shocking as the use of force, it reveals a casualness or callousness which can be equally culpable.

As with the police, stereotypes of dangerousness, illegality and untrustworthiness lead to a disregard for BME individuals by prison staff. And too often, there is a refusal to accept that symptoms of distress displayed by someone in their care (such as the groans and gasps of someone unable to breathe) are genuine. A failure to understand an individual's health problems (sometimes physical, more often mental), the inappropriate use of restraint or drugs, can be compounded by a lack of adequate healthcare. In a significant number of cases, information does not get passed on; health records are not sent on to the appropriate authorities.

Once health problems are highlighted, often no-one takes responsibility – 'a lack of care'. Often, there is a failure to assess risk: people with a history of self-harm are not adequately assessed or monitored, refused asylum seekers and foreign national prisoners awaiting removal or deportation, at risk to depression and self-harm, are often overlooked (see also Chapter 4).

Deaths ascribed to natural causes form a large proportion of recorded deaths in prisons. For example, according to the Independent Advisory Panel on Deaths in Custody (IAP), of the 192 deaths recorded in 2012, 121 were recorded as natural causes (62 per cent).[2] But careful examination shows other factors often at play, such as undiagnosed health conditions, or lack of access to appropriate treatment.

There are other deadly risks to BME prisoners which fail to be properly assessed: the harm that might potentially come to them from hostile white inmates or hostile guards intent on placing a person in a situation that makes them vulnerable. We flag up deaths of 'indirect harm' where treatment of BME prisoners has been negligent, particularly of physical and medical problems, and deaths caused by fellow inmates' violence where officers were negligent in

08/12/95 ALTON MANNING (33)

Manning died while on remand at Blakenhurst (private) prison,[4] West Midlands. Officers alleged that he turned violent during a routine cell search. As he was being escorted to the segregation wing, he was found not to be breathing. An (inconclusive) post-mortem had already been carried out by the time Manning's family were informed. The inquest into his death (the first control and restraint death in a privately-run prison) began in January 1998. It heard that when Manning refused to agree to an intimate body search by two officers who had searched his cell and person, he was restrained face down on the floor by another six officers, then carried face down by his arms, legs and head towards the segregation wing. Halfway there he was laid on the floor for officers to apply handcuffs, and blood was seen coming from his mouth. When checked, no signs of life were found. The second post-mortem showed that Manning died from 'respiratory impairment/ restriction during restraint' leading to asphyxia. The pathologist also found bruising to the neck and back which suggested that Manning had been restrained with a knee in his back and that pressure had been applied to the back of his neck. There were eight separate areas of injury to his face as well as abrasions to his arms and legs. At the inquest none of the officers could explain the injuries or how he suffocated to death. They maintained he had become aggressive and was restrained face down in accordance with Home Office-approved techniques. Despite Manning's many injuries and the violence allegedly used by Manning in the struggle, only one of the prison officers involved sustained injury - two scratches.

The officer who initiated the search was the only one to suspect possession of cannabis, a fact which he only made known at the inquest. He did not mention this in his written account of the incident nor in any statements to the police. But ordering a prisoner to squat for a search, and the subsequent use of force, would only have been lawful had there been prior suspicion of possession of drugs.

Two of the officers, one of whom admitted kneeling on Manning's back, denied any knowledge of the Home Office guidelines on the dangers of restraining someone in a prone position, or applying pressure to the neck, chest or abdomen, issued after the death in prison of Omasese Lumumba in 1991.[5] Other officers said they were aware of the dangers involved and had received training.

Two prisoners saw Manning being restrained in a neck lock, one said 'Manning was struggling. At first only one officer had a hold on him then others arrived and he was carried face down, with an officer on each leg and each arm and one on the neck.' At the inquest vital video evidence of the incident was unavailable, as were the first incident reports, which had gone missing.

The jury recorded a unanimous verdict of unlawful killing, after which seven prison guards were suspended pending a decision on whether to prosecute by the CPS, to whom the coroner referred the case. In March 1999, the CPS announced its decision not to bring criminal charges against the officers. The family went to judicial review and in May 2000 the High Court ruled that the CPS decision not to prosecute the officers was flawed and should be reconsidered. But in 2002 the CPS reiterated its decision not to prosecute the officers because of 'insufficient evidence'.

areas such as risk assessment and effectively placed them in harm's way.

Use of force

Deaths in prison, like deaths in police custody, can be based on stereotyping of BME individuals, which leads to an escalation of violence and a resort to the use of dangerous techniques and outlawed or unauthorised restraint methods. The use of undue force in attempts to restrain has featured in a number of controversial BME deaths in prison custody. There are of course guidelines and training in the prison services as to when and how control and restraint can be used. For example, according to Ministry of Justice guidelines for the prison service, 'control and restraint techniques' must only be used as a 'last resort after all other means of de-escalating (eg, persuasion or negotiation) the incident, not involving the use of force, have been repeatedly tried and failed'. 'Staff must continue to attempt to de-escalate the situation throughout the incident with the aim of releasing holds and locks,' the guidelines continue.[3] Examine the case of **Alton Manning**.

Another case where restraint ultimately led to death was that of **Gareth Myatt**, a teenager who died at the privately-run Rainsbrook Secure Training Centre[6] in Northamptonshire after being restrained by three staff.

Lack of care

Inadequate physical health care

Prison officers often hold stereotyped views of BME inmates as violent, dangerous individuals, which affects their treatment. Additionally, prisons are closed institutions, often with sclerotic procedures. Information about inmates' medical or mental health problems is sometimes not adequately communicated, training for medical emergencies poor. Misdiagnosis or lack of diagnosis and inadequate treatment, which we highlighted as a cause of black deaths in prison in 1991, still cause death. And the nature of prisons, closed off and separated from the outside world, hides from view deaths occurring inside them, with information usually available only from official sources (which cannot necessarily be relied upon).

Adejare (Paul) Akinbiyi, a 30-year-old severe asthmatic, died in his cell at Belmarsh prison after

19/04/04 GARETH MYATT (15)

Myatt had been sentenced to a 12-month detention and training order. Just three days into his stay at Rainsbrook, an altercation occurred after he refused to clean a sandwich toaster. Staff began removing personal belongings from his room as a punishment, and Myatt became more upset and allegedly lunged at one of the guards (who had tried to remove a piece of paper containing his mother's new mobile phone number). As a result, three guards restrained seven-stone, four-foot-ten Myatt using the 'seated double embrace' (where he was forced into a sitting position and leant forward).[7]

A training assistant told the inquest, 'Gareth was doing a lot of shouting and swearing. He did say at one stage that he couldn't breathe. Somebody said, "Well, if you are shouting, you can breathe." Gareth said he was going to shit himself. Somebody said, "Well, you are going to have to shit yourself, because we can't let you go while you are like this." Bailey looked back and said he had actually shat himself. The struggling seemed to go on for a while and then he seemed to settle down. After a few minutes we realized something was wrong. I looked at his face and he had something coming down his nose and he looked as if his eyes were bulging. I can't remember much more. I've tried to get it out of my mind.'

The jury found that the death was accidental but the Youth Justice Board was criticised in relation to its management responsibility for the safety and monitoring of Physical Control in Care at Rainsbrook, its failure to assess or undertake medical review of the safety of Physical Control in Care and the seated double embrace. Rebound Children's Services (a subsidiary of Global Solutions Limited [GSL]) was also criticised by the coroner for the lack of response to information from Rainsbrook.

In June 2004, the 'seated double embrace' was withdrawn from use within juvenile custody. In 2007, the coroners at the inquests into the deaths of Gareth Myatt and Adam Rickwood refused to make a ruling as to whether the restraint used in both cases was lawful. This led to a number of judicial reviews by the mother of Adam Rickwood (who committed suicide at Hassockfield secure training centre), ultimately resulting in a ruling at the High Court in 2009 that the force used had been unlawful.

suffering a succession of asthma attacks in March 1993. The doctor in charge at the prison hospital told the inquest that he was not informed by nurses of the seriousness of Akinbiyi's condition. The inquest recorded a verdict of accidental death brought about by lack of care.

Twelve years later, the death of 25-year-old **Godfrey Moyo**[8] in the same prison revealed not lack of recognition of a medical problem – his epilepsy was known to prison officers – but a more wanton failure to acknowledge the lethal nature of violent and prolonged restraint, although the danger of positional asphyxia to someone restrained face down was well known.

03/01/05 GODFREY MOYO (25)

A Zimbabwean on remand at Belmarsh prison, Moyo suffered an epileptic fit in his cell, and was restrained face down for at least thirty minutes by up to seven officers who were called to assist him. He was then carried to a cell in the healthcare unit where he was injected with a sedative and left on his knees, leant against a bed with his face to one side, for around an hour. When officers returned, he was not breathing. Resuscitation was started and an ambulance called. Moyo was pronounced dead at the Queen Elizabeth Hospital, Woolwich, nearly three hours after officers had first entered his cell.

In July 2009, an inquest jury heard how Moyo had suffered two earlier epileptic fits in Belmarsh, each accompanied by extreme involuntary violence, and had been hospitalised overnight each time. As to the final occasion, prison officers gave evidence that during the short journey to the healthcare unit Moyo continued to struggle so the restraint continued, although CCTV footage of (part of) the short journey showed Moyo seemingly unconscious.

At the healthcare unit, Moyo was taken to the intensive care cell (ICC), where a sedative was authorised by a doctor over the phone. He was observed through the hatch, but when, nearly an hour later, officers re-entered to make Moyo 'more comfortable' on the bed, he was not breathing.

The jury recorded a unanimous highly critical narrative verdict of neglect for Moyo who died from 'positional asphyxia, left ventricular failure following restraint and epileptic fits'. Officers had failed, they found, to monitor adequately his condition during the restraint, contributing to his death by neglect; failed to recognise his signs of distress during the restraint, and had made no attempt to move him off his front during the restraint, or place him in the recovery position when he was unconscious. In several respects, the jury found, control and restraint guidelines were breached. Coroner Andrew Walker commented that 'there was a complete lack of understanding of epilepsy by all who came into contact with Moyo. The system was fundamentally flawed and steps must be taken to prevent future deaths.'

According to our data, at least twenty-eight prisoners who died, some of whom are classified as dying from natural causes, also faced some contributory neglect of their medical condition.

Inadequate mental health care and aggravated suicide

The suicide rate in prisons is almost fifteen times higher than in the general population, according to the Mental Health Foundation. Nearly three-quarters of the prison population have two or more mental health disorders, it claims, and the incidence is higher for ethnic minorities, as well as for women and older people.[9] Figures from the IAP[10] show that between 2000 and 2011, 14 per cent of self-inflicted deaths in prison were by BME individuals. INQUEST's statistics show that of 399 BME deaths in prison[11] since 1991, 215 were self-inflicted.

24/03/05 MICHAEL BAILEY (23)

Father of one, Bailey was found hanged in his cell in March 2005 in the segregation unit of Rye Hill prison in Warwickshire, a private prison run at that time by GSL. He was said by staff to be 'vocal on racial issues' and 'aggressive', of 'incredible strength', and was subject to control and restraint on a number of occasions. In segregation following an altercation, he became very volatile, said he wanted to die, stripped naked during exercise and recited from the Bible. Marks round his neck and wrists were visible during a family visit, but he was not transferred to the healthcare unit despite his fear of segregation. A unit manager who saw him slumped against the cell door believed he was 'playing up'; in fact he had hanged himself with a shoelace. An inquest into Bailey's death found that he 'killed himself whist suffering from a mental illness' and that factors contributing to his death included failures in communications; failure to carry out mental health assessments; failure to recognise his mental distress; a lack of trained and experienced staff; a lack of management of the segregation unit; systemic failures in the training, implementation and operation of the suicide and self-harm policy. The coroner said that the death was avoidable. The Prisons and Probation Ombudsman (PPO) found that there had been 'both an appalling breakdown in procedures and a lack of sensitivity and kindness (or worse) in the treatment of a vulnerable and broken man'.[12] Police charged three staff members with manslaughter by gross neglect, and with attempting to pervert the course of justice by tampering with notes to cover up their guilt, but the judge at the trial ruled there was no case to answer since it could not be proved that the neglect caused the death.

A month after Bailey's death, HM Inspector of Prisons carried out an unannounced inspection of Rye Hill and was alarmed to find an 'unsafe and unstable environment' for prisoners and staff. Very low staffing levels and high staff turnover were exacerbated by lack of visible management presence, and 'no strategies were in place for dealing with the mentally ill.' She made urgent recommendations.[13]

10/06/06 ALEKSEY BARANOVSKY (33)

A Ukrainian, Baranovsky bled to death in his cell at Rye Hill. An inquest was told that, in protest at his impending deportation after serving a seven-year sentence, and in fear of being killed by the Russian mafia if deported, he had repeatedly self-harmed with razor blades (which were never taken from him), until he died from anaemia due to chronic blood loss and under-nutrition. It transpired that a proper mental health assessment was never carried out and his request to see a doctor hours before his death was not followed up. Even his request for water was ignored. Staff made no attempt to help him and despite being monitored under self-harm procedures, he was left kneeling at the end of his bed, arms and head resting on it, too weak to get on to it, until it was realised that he was not breathing. The coroner called his treatment 'unacceptable', 'shameful and appalling'. In September 2009, the jury recorded a highly critical narrative verdict outlining a catalogue of failures relating to suicide prevention and the need for urgent psychiatric assessment and communication between staff.

An investigation by the PPO found that staff of Primecare Forensic Medical (PFM), the sub-contractor then running healthcare at the prison, failed to accept responsibility for his health and well-being, that he was treated in an unprofessional way and did not receive 'the level of care, decency and medical treatment that he was entitled to receive from some staff at Rye Hill'. The PPO concluded, 'this is as sad and shameful account as any I have penned in the near five years I have been investigating deaths in custody'.[14]

Kwaku (Andrew) Ohene, a mentally ill man, took his own life in the hospital wing of Swaleside prison, Isle of Sheppey in June 1991. He had a history of mental illness and at no time was he properly assessed despite being a known suicide risk. An inquest recorded a verdict of death 'aggravated by lack of care'.

Jason Sebastian was found hanged from the bars of his cell window while on remand at Belmarsh prison in September 1997. He had a long history of mental illness and had been diagnosed as schizophrenic. Despite warnings about the state of his mental health and recommendations by his psychiatrist that he be placed in healthcare, he was placed in the segregation unit for four days after verbally abusing a member of staff. He was found hanged there a few days later. The inquest, held in February 1998, recorded an open verdict. The jury heard how there had been a 'breakdown in communication' after the letter from his psychiatrist and an 'exceptional risk' form from the police reached the prison but were not passed to the prison doctor.

Keita Craig suffered serious mental health problems and took his own life while on remand in Wandsworth prison in February 2000. Although he was classed as a suicide risk he was allowed to have his shoelaces, previously taken from him. At the inquest in April 2000, the coroner refused to allow the jury to consider a verdict incorporating neglect, and they found that Craig had 'killed himself whilst the balance of his mind was disturbed'. In February 2001, on a judicial review of the coroner's direction, the High Court ordered a fresh inquest, which, in October 2001, led to a rider to the verdict, stating that neglect contributed to the death.

Some of the worst cases of death by neglect in prison arise from treating the desperation which leads individuals to self-harm as 'manipulation'. When the stereotype of the 'manipulative' prisoner meets that of the violent or dangerous BME individual, the result can be inappropriate or no treatment. But additionally, where prisons are privatised, lines of accountability are so attenuated as to be virtually meaningless. Procedures such as risk assessments are

12/06/09 CHRISTOPHER WARDALLY (25)

Wardally had suffered from severe mental health difficulties but was making plans for study and a life abroad. He was on licence but had been recalled to prison after a remand in custody for driving offences, because probation staff wrongly believed he had breached curfew and reporting conditions. He attempted to take his own life the day after being sent back to prison (Pentonville) on 22 April 2009. He sought transfer to Wandsworth prison, fearing rival gang members in Pentonville, and because Wandsworth was closer to his family. He was transferred, but following a court appearance was sent back to Pentonville prison, and held there with four 'problem' prisoners who had been moved out of Wandsworth during an HMIP inspection. At Pentonville he again tried to take his own life. By the time he arrived back in Wandsworth following the inspection, he was 'like a small child in distress', according to other prisoners who comforted him, and he told a doctor that the gang members at Pentonville had threatened to hurt his family and that only his death would lift the threat. Despite his mood and the concern for him expressed by other prisoners, he was not put into the healthcare unit (as he had been in Pentonville). When he took his own life, three days after returning to Wandsworth, he was in a cell alone, with only intermittent daytime observation.

The PPO found that communication problems between the prisons meant healthcare staff at Wandsworth were unaware of the deterioration in Wardally's mental health and even of his return, the risk assessment was faulty and his 'frequent and unpredictable transfers from prison to prison are likely to have exacerbated his fragile mental state ... significantly increasing his risk of harm to himself'.[16] A separate report by HMIP found that prisoners were being transferred between Pentonville and Wandsworth under a reciprocal arrangement to ensure that 'problem prisoners' were out of the way during her inspections. The Chief Inspector (CI) at the time, Anne Owers, condemned the 'irresponsible, pointless and potentially dangerous' prisoner transfers designed to 'subvert the inspection process', with prisoners treated as 'pieces to be moved around the board to meet performance indicators or to burnish the reputation of a prison'.[17] Three prison governors were disciplined as a result.

reduced to empty tick-box exercises and no one takes responsibility – as in the case of **Michael Bailey**.

But the death of **Aleksey Baranovsky**, a foreign national, just over a year later at the same prison, showed that lessons had not been learned.

The death of **Christopher Wardally** at Wandsworth prison in June 2009 raises concerns of failures of risk assessment and monitoring, inadequate healthcare facilities[15] and frequent transfers for purposes other than the welfare of prisoners.

According to our figures 157 (45 per cent of the 347) deaths related to self-harm. The figures are rising as cuts bite and fewer prison staff care for more prisoners. In September 2014, referring to a 64 per cent rise in suicides across the detention estate in the past year, the PPO said, 'there have been too many instances of prisons failing to adequately identify the risk of suicide posed by prisoners, despite clear warning signs being present. Even when risk of suicide was identified, monitoring arrangements and case reviews were too often inadequate.'[18]

Foreign national prisoners (FNPs)[19]

Baranovsky was a foreign national prisoner, a group who are particularly vulnerable to self-harm and suicide through despair, but who are subjected to a prison regime which can exacerbate these risks. Many FNPs have fled horrific violence and are terrified of return to their country. The specific additional problems foreign prisoners bring with them – language difficulties, lack of family ties, issues around their immigration status and perhaps fear of return home – combine to create isolation, depression and confusion. But at the end of their sentence, FNPs, unlike British prisoners, can be (and often are) held under Immigration Act powers for deportation, sometimes for lengthy periods. They are often excluded from rehabilitation or pre-release programmes. The 'care and awareness of others' said to be at the heart of a healthy prison[20] has too often been lacking, for vulnerable FNPs. And when there is a death, there is often no family in the UK able to hold the prison service or the Home Office to account for failures of care. An HMIP thematic report of July 2006[21] - the first to look at foreign prisoners as a group - condemned the prison service' rejection of national standards for the conditions and treatment of FNPs, who were not given support or coherent planning for release or deportation, or help with their specific vulnerabilities – lack of family ties, language problems, fear of return. On the contrary, HMIP found prison staff to be intolerant of language and cultural differences, and Muslims and BME prisoners reported discrimination. Non-English speakers had the greatest problems.

Of the six deaths in Lewes prison in 2001-2002, three were of foreign national prisoners with English as a second language. One of these, Iranian **Nariman Tahmasebi** (27), had fled to the UK after detention in Iran for his political beliefs. Refused asylum here and fearful of return, he was caught trying to board a plane to Canada using the forged travel documents he had arrived with. He was sentenced to six months imprisonment, arriving at Lewes prison on 14 February 2002. He hanged himself from the bars of his cell with a sheet on 20 February. At the inquest, the jury heard that all his interviews with prison staff – on arrival, an induction interview the next day and a health care interview – were conducted

in English with no interpreter, although Tahmasebi's English was poor. Despite his telling guards that he had overdosed in Iran after being beaten by prison guards, and that he would contemplate harming himself if he was threatened with return to Iran, they did not treat him as a suicide risk, putting him into a single cell where he was found hanged the following night, dying five days later in hospital without regaining consciousness.[22] The jury returned a verdict of misadventure.

Until 2006, foreign prisoners were largely invisible in British prisons, although their numbers tripled in a decade to 10,000, or 13 per cent of the prison population in April 2006. In that month, a political and media scandal erupted over the revelation that, since 1999, just over a thousand foreign national offenders had been released at the end of their sentence without the Home Office considering whether they should be deported, in pursuance of powers of deportation of foreigners committing offences. Home secretary Charles Clarke was forced to resign, and under his replacement John Reid, thousands of foreign offenders were rounded up and detained for long periods awaiting deportation.[23] The crackdown on foreign offenders took its toll in a dramatic rise in prison suicides of FNPs: from an average of three to four a year to eighteen or twenty-three in 2007 (the number went down to eight in 2008.)[24] PPO statistics from 2004-13 show that 17 per cent of self-inflicted deaths in prison were of FNPs.[25]

Three deaths at HMP Chelmsford – in 2007, 2008 and 2011 – illustrate some of the additional problems faced by FNPs. Teenage Darfuri refugee **Abdullah Hagar ('Joker') Idris** was due to be released in January 2008 but on Christmas Eve 2007 was served with a notice saying he would remain in detention for deportation, and he killed himself the following day. Two months later, troubled 18-year-old **Vinith Kannathasan**, a Sri Lankan Tamil refugee, hanged himself at the prison. And in July 2011, a young Vietnamese trafficking survivor, **Tuan Ho**, killed himself after accepting voluntary return to Vietnam, and after his Vietnamese cellmate was transferred to an immigration removal centre. These deaths bear out the findings of an October 2007 thematic review which had found a failure of healthcare staff to address the emotional and mental vulnerability of FNPs in the prison estate, but also raise questions about the mandatory deportation of vulnerable young people who have spent much of their lives in the UK.[26]

Inadequate risk assessment and exposure to racist violence

Poor risk assessment in prison does not just relate to failures to protect inmates from harm, often by their own hand; it can also involve actually putting them in harm's way. This occurs when a lack of care is exercised in the placing of BME prisoners in cells with hostile racists, and/ or not anticipating or reacting appropriately to situations involving inter-prisoner racial violence.

21/03/00 ZAHID MUBAREK (19)

Mubarek was just hours from being released from a ninety-day sentence at Feltham Young Offender Institution (YOI) when he was brutally attacked by cellmate Robert Joseph Stewart, who had a history of violent and racist behaviour. Stewart was jailed for life for his murder in November 2000. Following the death, there were allegations that prison officers held 'Gladiator Games' by putting unsuitable prisoners together in cells and placing bets on the outcome, although no inquiry found evidence to support the allegations.

After agitation by Mubarek's family and a family campaign, a number of inquiries and investigations were carried out into this death – by the Prison Service, the Commission for Racial Equality (which found race discrimination at the prison) and the Metropolitan police.[27] An inquest was opened and adjourned pending Stewart's trial, and not resumed. It was sustained campaigning by the family that led to an eventual full public inquiry.[28]

The public inquiry into Mubarek's death, set up in April 2004 and chaired by Mr Justice Keith (a High Court judge), was tasked with examining the events leading up to the murder and making recommendations to prevent such deaths in the future. It heard evidence of how racism at Feltham YOI was ignored by prison guards and allegations that guards were actually complicit in creating the conditions that led to Mubarek's death.[29] The inquiry had sixty-seven public hearings, read statements from 116 people and took oral evidence from sixty-two witnesses. It issued its findings in June 2006, and identified 186 failings which led to Mubarek's death. Its main findings were that the prison was blighted by institutional racism, and by a failure to tackle overt racism, with racist language or banter not taken seriously by staff and some ethnic minority officers reporting victimisation. In this atmosphere, 'chance after chance to spot the danger that Stewart posed was missed or not acted on'. The inquiry found he was so dangerous he should never have shared a cell with anyone, let alone a BME prisoner. Evidence of his severe personality disorders was not passed on; his tattoos, which if properly interpreted were evidence of his racist beliefs, and letters in which he fantasised about racial violence and even killing his cellmate, were ignored.

On 30 June 2014 the CI of Prisons, who had reviewed developments since the death, said that such a death could happen again. The reforms originally introduced to risk assessments, particularly in cell-sharing, monitoring of violence and cell overcrowding, had been weakened or forgotten.[30]

02/04/04 SHAHID AZIZ (30)

In April 2004, four years after Zahid Mubarek's death, Aziz was strangled and had his throat cut at Leeds prison half an hour after being put in a cell with Peter McCann, who hit him repeatedly with a blunt implement (probably a chair) as he lay dying. McCann denied being racist, and the police and the CPS asserted that the murder was not racially motivated.

In July 2004, McCann pleaded guilty to murder and was sentenced to life imprisonment, with a 12-year tariff. With a history of violence and of fashioning home-made weapons, McCann had attacked other prisoners (including a black prisoner) on several occasions. He objected to having to share a cell with an Asian and to Aziz using his own language. Aziz had previously highlighted the issue of racism at the prison and the differential ways in which Asian prisoners were treated. His allegations of racism at the prison, together with those of twenty mainly BME current or former prisoners at Leeds, were submitted to the Commission for Racial Equality, the PPO and the Prison Service.

The PPO's report into Aziz's death showed up the vacuity of the cell-sharing risk assessment exercise. McCann's history of violence and weapons was not recorded, and the assessment consisted almost entirely of staff asking McCann if he was dangerous. 'The information upon which staff at Leeds based their decision [for the two men to be placed in the same cell] was extremely limited, and I am particularly concerned that the situational aspects of the defendant's previous violence were not identified.'[31] The other particular concern expressed by the PPO was Leeds' approach to 'issues of diversity and race', which he found 'does not make happy reading'.

Norman Washington Manning died at Long Lartin prison in September 1994 after suffering sixteen stab wounds at the hands of alleged racists. His family led a campaign to charge the men involved. One man was convicted and another was found not guilty.

Majahid Ahmed (25) was found hanged on 1 July 1996, while on remand in Leeds prison, and died on 21 October. It was first thought to be suicide, but fellow inmate Christopher Brasher (23) was later arrested (a month or so before Ahmed died) and charged with attempted murder. The inquest recorded a verdict of unlawful killing and the prison service classified the death as a 'homicide non-self-inflicted'. However very little information is available on this death so it cannot be known if the murder was racially motivated.

But it was the death of **Zahid Mubarek** which really brought the issue of racism in prison into sharp focus. And **Shahid Aziz** was to die soon after.

These cases are not isolated, but are an inevitable result of a hidden culture of institutionalised racism in many prisons, which is so rarely exposed to the light of day. In 1998, the police launched an investigation around 100 prison guards at Wormwood Scrubs prison in west London, following allegations of racism and brutality from up to eighty prisoners. Three officers were subsequently convicted of assault in September 2001, six officers were dismissed and over £1.3 million was paid in damages in over fifty cases. More recently, a 2005 thematic review by HMIP of race in prisons found that 'Most [black and ethnic minority prisoners] believed that there was racism ... [which] manifested itself in differential access to the prison regime and treatment by staff – such as the way prisoners were spoken to, searched and had their requests dealt with, or the length of time they waited for the things they wanted or needed. They often linked this to a lack of cultural and racial awareness; and criticism was particularly strong in prisons with low numbers of visible minority prisoners and staff.'[32] The report found white staff complacent in the belief that race was being tackled effectively and unaware of ethnic minority colleagues' frustration and sense of exclusion. The following year, police began an investigation into allegations of racism and violence by 'a hard core of rogue officers' at Whitemoor prison in Cambridgeshire.

Conclusion

As with deaths outlined in the previous chapter, sadly the cases examined here reveal lack of care and disregard for human life that is so blatant that it often appears as deliberate acts and omissions by individuals and institutions.

A number of areas of concern emerge from an examination of cases over time:

- A disproportionate level of force used on BME individuals within prison custody;
- The stereotyping of individuals without any evidence as violent, volatile and /or mad;
- A lack of training in potentially dangerous restraint methods;
- A compounding of this lack of training in the use of private companies to which custodial functions are sub-contracted;
- Neglect of prisoners' medical conditions;
- Lack of strategies for addressing mental illness;
- Inadequate risk assessments;
- Failure to recognise the particular vulnerability of FNPs;
- A failure to apply lessons learned from earlier fatalities, which means similar deaths take place;
- A consistent failure to hold officers to account.

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4 | Deaths in immigration detention and during deportation

A LARGE NUMBER of those imprisoned at any one time in the UK are not inmates serving sentences but asylum seekers or those suspected of immigration irregularities, in the 'fast track' process awaiting a decision, or held for removal following refusal of their claim. In 2013, over 30,000 people entered immigration detention, and, at the end of December, 2,796 people were detained under the Immigration Acts.[1] The detention regimen, although technically not supposed to be as punitive as the conventional prison system, has a culture of racism, sexism and dehumanisation of its own; issues of lack of accountability, professionalism and training constantly surface.

Culture of racism

Racism in Immigration Removal Centres (IRCs)[2] is an accepted fact of life for detainees: there is racism in the casual way people are treated; racism in the language used towards and about them; and racism in the very structures of the system that created the centres.

In March 2014, the Home Office published figures for staff dismissed for misconduct from 2008 to 2013. Although the figures do not specify numbers dismissed for racism, they are indicative of what goes on: eight were dismissed for bullying, harassment and discrimination; six for verbal or abusive behaviour (230 were dismissed in total).[3] In 2006, a HMIP report into Harmondsworth found that two-thirds of detainees felt unsafe and nearly half said they had been victimised by staff.

With immigration detainees cut off from mainstream society and mainstream paths to redress, it has often been the media that has exposed the levels of degradation and racism in detention.[4] In 2003, after allegations of racism and brutality at Yarl's Wood by investigative journalist Nick Sommerlad who had worked undercover as a guard,[5] an inquiry, the first such, was carried out by the PPO. Though the report found his allegations only substantiated in relation 'to a small handful of people' it did, nonetheless, state that the UKBA should 'consider providing additional training on race relations and cultural awareness'; as the PPO, Stephen Shaw, commented: 'Racism can take many forms.'[6]

Again, in 2005, a BBC programme *Detention Undercover: the real story* revealed racism and abuse at Oakington and during the deportation process. The PPO subsequently reported: 'Whilst we have no evidence of "a widespread culture of racism towards detainees" it cannot be denied that a small minority, mainly confined to one shift, have constantly behaved in a racist manner towards the detainees.'[7]

Most recently, during the inquest into **Jimmy Mubenga**'s death (May–July 2013), serious allegations of racism emerged after two of the three G4S guards involved in the deportation and subsequent death of Jimmy Mubenga (see below) were found to have offensive racist texts and jokes on their phones. The coroner, in her Rule 43 report following the death, reported in no uncertain terms that: 'These texts were not evidence of a couple of "*rotten apples*" but rather seemed to evidence a more pervasive racism within G4S. Evidence provided in the run up to the Inquest about these texts from one of the DCOs was to the effect that "*lots*" of his work colleagues and acquaintances would send such material between themselves.' She also found that: 'It seems unlikely that endemic racism would not impact at all on service provision. It was not possible to explore at the Inquest the true extent of racist opinion or tolerance amongst DCOs or more widely. However, there was enough evidence to cause real concern, particularly at the possibility that such racism might find reflection in race-based antipathy towards detainees and deportees and that in turn might manifest itself in inappropriate treatment of them. As it was put by one witness, the potential impact on detainees of a racist culture is that detainees and deportees are not "*personalized*." This may, self-evidently, result in a lack of empathy and respect for their dignity and humanity potentially putting their safety at risk, especially if force is used against them.'[8]

The impact of privatisation

The dehumanisation of detainees which leaves them vulnerable to racism (and sexual abuse)[9] has, we believe, been considerably enhanced by

the privatisation of detention services. For the interception and removal of unwanted individuals is now part of a global growth industry, sub-contracted to the private sector. Huge multinational companies (with turnovers higher than the Gross Domestic Product of whole countries) order the lives and oversee the deaths of waiting deportees. The contracting-out of this aspect of state policy has been gathering speed since the 1980s; today IRCs are nearly all run by private security companies. A separate custodial system now exists for this specific group, who have been largely separated from the prison population at large, and placed in mostly purpose-built removal centres, subject to their own rules.[10]

Private companies employ their own detention custody officers as well as a small number of on-site Home Office officials, with healthcare at IRCs usually further sub-contracted out to other private companies (some of which are subsidiaries of the contractors running the centres). By devolving its duty of care to private companies, the Home Office shifts any responsibility for wrongdoing to whatever company is running the centre at the time. And the nature of privatisation results in a steady succession of private companies passing through the revolving doors of the detention regime, shifting contracts to get the best price, dropping one in favour of another if a scandal has broken. Detention, transportation and deportation are not about people, but objects, not welfare but profit. (Nowhere was this made clearer than in one contract which had a clause stating that a detainee's successful self-harm attempt would result in a financial penalty for the company – a kind of bounty in reverse.)[11]

This distancing of government from responsibility, and the sheer number of firms involved in the asylum process, adds to the lack of accountability following deaths in IRCs. After such a death, contractors are frequently replaced by the Home Office – thereby shifting the chain of responsibility. The new firm will claim that it has the necessary policies and procedures in place to prevent such deaths occurring, but often the same mistakes are repeated.

Take Harmondsworth. It opened as an immigration detention centre in the 1970s after being converted from a YOI, and was run by Securicor.[12] In 1999 Burns International won the contract to operate the centre. Following Robertus Grabys' death in 2000, United Kingdom Detention Services (owned by Sodexho) won the contract to run the centre, which reopened, enlarged and refurbished, in September 2001. It had to close in July 2004 following a disturbance after the death of Sergey Baranyuk, reopening in October 2004. (In October 2006 the Centre renamed itself Kalyx.) The GEO Group took over in June 2009 under a three-year contract worth approximately £11 million.[13]

The companies involved in the detention of asylum seekers, eg, G4S, GEO Group Ltd, Serco, Tascor and Mitie, are also involved in the provision of ancillary services to the Home Office, such as escorting detainees to and from removal centres, escorted removals from the UK and housing for asylum seekers. Concerns have been expressed about these companies' unfailing abilities to win government contracts despite consistent failures in performance.[14]

There may be a lack of scrutiny of and accountability built into the detention system, but it is important to note here that, just as there is a vibrant campaign for those whose families have lost loved ones in prison and police custody, there are similar campaigns in this sector too. It is not built so much by family members (who are often not in this country) but by 'a political family' of individuals and groups already campaigning against policies of detaining and deporting vulnerable asylum seekers – such as Bail for Immigration Detainees, Black Women's Rape Action Project, Campaign to Close Campsfield, Corporate Watch, Detention Action, End Child Detention Now, International Federation of Iraqi Refugees, Medical Justice, No-One is Illegal, Right to Remain (formerly the National Coalition of Anti-Deportation Campaigns), The Unity Centre, Movement for Justice, No Borders, No-Deportations, Stop Deportations, Stop Arbitrary Detention in Yarl's Wood and Women for Refugee Women.

And when people in such groups get calls, texts, tweets or smuggled messages about ill-treatment or a suspected death, they can immediately swing into action and alert the world beyond the razor wire.

Deaths in detention

There have been twenty-two deaths in IRCs since 2000, of whom three were women. Harmondsworth accounts for eight deaths; three people have died at Colnbrook and two each at Campsfield, Haslar and Yarl's Wood. One person has died at each of the detention centres: Dover, Dungavel, Oakington (now closed) and Pennine House (a short-term holding facility). And of the twenty-two deaths, eighteen took place in centres run by private companies.

According to the Home Office *Enforcement instructions and guidance manual*, vulnerable people including unaccompanied children, the elderly, pregnant women, those suffering from serious medical conditions or serious mental illness, those with independent evidence of torture; people with serious disabilities and those identified as victims of trafficking should be detained 'only in very exceptional circumstances'.[15] But pregnant women, torture and trafficking survivors and those with serious medical and mental conditions *are* regularly

detained. Physical and psychological ill health are made worse by being detained and by the conditions of detention.

Aggravated suicides

Of the twenty-two deaths in IRCs, seven were ruled by an inquest as self-inflicted or the result of self-harm attempts. Asylum seekers may be kept in 'administrative' detention for lengthy periods, sometimes years, often extended by bureaucratic lethargy and downright inefficiency – which leads to depression, other mental illness, self-harm and suicides. Detention Action found that 'Indefinite detention, lasting for years without a release date, causes distress and psychological deterioration that is out of all proportion to the immigration goals sought ... [with] significant numbers of indefinite detainees developing mental health problems, self-harming or attempting suicide. Interviewees described their despair at seeing no way out of detention.'[16]

According to No-Deportations, in 2013, attempted suicides in IRCs 'hit a record high of 325' with 'one attempt on average every 27 hours'. 'Brook House [was]... the worst IRC for self-harm and those on self-harm watch for the second year running.' In the last quarter of 2013, at least six people were classified as at risk of self-harm at the so-called 'family-friendly pre-departure accommodation', Cedars.

The custodial services cannot be blamed for immigration decisions or for the unjust nature of the law. But the mostly privatised immigration detention estate is marked by a whole series of failings – from failing to pass on medical records, not providing interpreters, not carrying out risk assessments to failing to keep watch over or provide medication to someone deemed a suicide risk, as the cases below illustrate.

Robertus Grabys, a Lithuanian refused asylum seeker, hanged himself in a shower room at Harmondsworth IRC near Heathrow airport on 24 January 2000. Picked up by the police ten days earlier, he had been seen to remove his shoelaces, and was kept under observation until his transfer to Harmondsworth. His self-harm risk was communicated to Harmondsworth, but, according to a report commissioned by the Home Office, reception staff gave insufficient weight to it. His death was 'a culmination of failures in the systems and procedures of both Burns International [the contractor then running Harmondsworth] and the Immigration Service'.[17]

The cumulative impact of indefinite detention and the failures of removal centres in responding to the urgent physical and psychological needs of inmates can be seen in the 'sad and shameful' story of **Sergey Baranyuk.**

19/07/04 SERGEY BARANYUK (31)

A Ukrainian asylum seeker was found hanged in a shower room at Harmondsworth while awaiting voluntary removal.[18] At the inquest it emerged that little was known about Baranyuk, who was not remembered by officers at Harmondsworth and whose roommate described him as 'introverted and quiet'. According to his family, Baranyuk, a divorced construction worker with an 11-year-old son, came to Britain to earn money to support his mother. He had arrived in the UK on 24 May 2004 and claimed asylum the following day at Lunar House, Croydon. At his screening interview, he was seen speaking into his crucifix as if it were a phone. He was taken to Oakington for assessment of his claim under the 'fast-track' system. Then, because of his disturbed behaviour, he was re-transferred within days to Harmondsworth, having decided by then that he wanted to go home and would withdraw his asylum claim. At Harmondsworth, he was incorrectly assigned to the fast-track system. At his medical screening, he was found to be anxious, and refused to speak about marks on his arms. The nurse did not consider Baranyuk to be at any risk of suicide or self-harm, but had not been supplied with any records from Oakington, nor did she have transfer records which noted that he had special needs, had been 'disruptive' and was a suicide risk. He had no further contact with the healthcare unit.

Following an interview with an immigration officer in which his return home was discussed, he remained in detention at Harmondsworth for over six weeks, waiting to be sent home, with no contact from immigration officials, no explanation for his continued detention or its possible length, and no information on the progress of his request to return. 'There was a lamentable failure to drive the man's case and to engage with him', the PPO found. Yet bail was refused for fear that Baranyuk would abscond, a decision the PPO criticised as arbitrary. His detention should have been reviewed every seven days but there was no evidence that this was done, and paperwork was generally 'slipshod'. The immigration officer failed to lodge an application for travel documents. On 5 July, an immigration officer checking Baranyuk's immigration file found that no travel documents had been applied for or received, which triggered a transfer into long-term detention. He then became the responsibility of another department – MODCU (Management of Detained Cases Unit), and on 16 July he received a two-line letter confirming that he had been transferred into long-term detention. It is not known whether he understood this letter, or what he thought when he read it. A 'redocumentation interview' was scheduled for 19 July, but he could not be found. Baranyuk had been seen (on CCTV) at 10.50am heading towards the shower room. Two attempts were made to find him for his immigration interview. At 7.15pm, a senior detention custody officer (DCO) was alerted to the fact that he was missing; he had missed two meals and the appointment with immigration officials. The residential manager, concerned that Baranyuk might be attempting to abscond, issued instructions for staff to guard the perimeter. At 7.50pm, DCOs found his body, some nine hours after he had last been seen alive. He had hanged himself in the shower. The jury found that he took his own life. The PPO found the story 'sad and shameful'.

11/07/04 KENNY PETER (24)

This African asylum seeker died in Charing Cross Hospital nearly three weeks after jumping from a second-floor landing in a self-harm attempt at Colnbrook.[19] On 15 September 2006, an inquest jury found that Peter had taken his own life, but also listed numerous failures by the authorities in whose care he was.

He had been arrested in Liverpool after stowing away on a ship in Gabon and on 4 November 2003 claimed asylum; he was taken to Oakington reception centre where, twenty days later, his claim was refused. He was released into National Asylum Support Service (NASS) accommodation in Ipswich pending an appeal, which was dismissed. He was then sent to Harwich short-term detention facility pending removal – gaining 'temporary admission' on health grounds. He was then admitted to an Ipswich psychiatric hospital. Hospital notes suggested that destitution was adding to his mental deterioration and that he could be suffering post-traumatic stress disorder. After he stopped reporting regularly to the police, he was arrested in an operation looking for illegal agricultural workers and transferred to Serco-run Colnbrook for removal.

There Peter was deemed fit to be detained, though he explained at the initial health check on 28 September 2004 that he had mental health problems and was on anti-depressants. Healthcare at Colnbrook was sub-contracted to Primecare Ltd, a subsidiary of Serco. The nurse took his pills away, after giving him one tablet. Meant to be seen by a doctor the next day, he was not in fact seen till eleven days later (after three days of stomach pain). He spoke about hanging himself and a 'self-harm at risk' form (SHARF) was opened. Only then was the anti-depressant Mirtazapine reinstated. (A sudden break in taking such anti-depressants can contribute to severe mood swings.)

A doctor who saw him on 9 and 10 October noted both times that Peter should be referred to a psychiatrist. But no one on the medical team followed this up, nor were his notes requested from the Ipswich hospital. Despite Peter being placed under observation for self-harm, this was not communicated to the various departments overseeing his detention. It was neither on his file at Colnbrook nor on his Felixstowe immigration file.

On 12 October, after an unsuccessful attempt to take his life by jumping from a landing with a ligature round his neck, Peter was placed under constant supervision and another note made that he should see a psychiatrist. Just four days after his suicide attempt, he asked to be moved from the medical centre to a wing where he would be under a less stringent SHARF supervision. Yet another note was made that he should see a psychiatrist (this request was made at least six times in all but never acted on). Three days later, on 7 November 2004, Peter walked from his ground floor room to the second floor where he tied a sheet to railings to act as a noose, and jumped. The sheet gave way but remained round his neck as he hit his head and slipped through a netting gap to the floor. The last words he reportedly mumbled as he lay on the floor, with blood round his mouth, were 'leave me alone'.

The last two pages of the jury's 12-page inquisition listed numerous deficiencies, failures and missed opportunities by the healthcare unit, detention centre staff and immigration staff.

An HMIP inspection of Harmondsworth two years after Baranyuk's death, following another suicide, described an 'over-emphasis on physical security ... more appropriate to a high security prison than a removal centre' and a 'purely bureaucratic' suicide prevention action plan not shared with the suicide prevention team nor the staff in the centre, which 'had no impact on the centre's practices'.

Less than six months after Baranyuk's death, **Kenny Peter**, another immigration detainee, committed suicide at Harmondsworth's neighbouring centre, Colnbrook IRC.

At least five of the eleven individuals who killed themselves in IRCs did so before an imminent deportation. Yet even when a detainee is obviously fearful of being sent home, Home Office officials never reconsider their decision to refuse asylum, instead commonly seeing suicide threats or self-harm as 'manipulation'. **Manuel Bravo** showed no signs of being suicidal, but his death following the decision to remove him raised questions over Home Office decision-making processes.

Manuel Bravo, who had lived in the UK for three years, was found hanged in a stairwell in Yarl's Wood on the morning of his 35th birthday, the day he was due to be returned to his native Angola, in September 2005. He had been detained with his 13-year-old son after an immigration raid at his home. Manuel left a note saying: 'I kill myself because I don't have a life to live any more. I want my son Antonio to stay in the UK to continue his studies.' The inquest jury heard about a series of failures in the asylum system that resulted in Bravo representing himself at his appeal hearing after his lawyer failed to attend. Following the dismissal of his appeal, an immigration official came to his house and said he would help him – but the next day he returned with enforcement officers and a battering ram.[20]

Following Bravo's death, recommendations were made in relation to healthcare and the prevention of self-harm. It was not the first time such recommendations had been made; they were made following the self-harm death of Robertus Grabys, and again following **Trang Quang Tung**'s death in Dungavel in July 2004, and again following the death of Kenny Peter, and again following the death of **Ramazan Kumluca** in June 2005 in Campsfield. Yet more recommendations were made after the death of **Bereket Yohannes** in January 2006.

Failure of healthcare

The other main cause of death in immigration detention, implicated in at least eight deaths, is lack of care in medical emergencies or inadequate treatment of an existing or deteriorating medical condition. Healthcare provision in IRCs is not the same as provided in prisons, where in theory, NHS-equivalent care is the standard. However, according to new Health and Justice Commissioning Intentions 2014/15, published in May 2014, one of the key priorities listed was 'Ensuring timely and effective transition of commissioning responsibilities of healthcare in Immigration Removal Centres.'[21]

Healthcare provision at IRCs has been subject to criticism not only in the aftermath of deaths, but also in regular HMIP inspection reports. In August and September 2005, following the deterioration in health of two Ugandan women who were on hunger strike at Yarl's Wood, at the time operated by GSL (now G4S), an inquiry was ordered into their care. The inquiry also examined healthcare management and delivery at the centre, and the links between management of healthcare and management of detention.[22] It found that many women at Yarl's Wood should not have been detained and that the Home Office was 'unresponsive ... to clinical concerns about an alleged history of torture or adverse medical consequences of continued detention'. And 'when clinical concerns were raised, the information was not systematically addressed or actioned.'

But there was severe criticism, too, of the 'inadequate' systems of healthcare operated by the private subcontractor, Veritas, which undermined the efforts of 'committed' and 'caring' individual staff. Although basic healthcare provision was found usually adequate for short-term detainees, it was 'not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well-being.' Complex management arrangements for healthcare meant 'it was not easy to establish where responsibility for specific service delivery lay'. Criticisms included 'lack of needs assessment, weak audit and clinical governance systems, inadequate staff training (particularly in relation to trauma) and insufficiently detailed policies and protocols ... Mental health care provision was also insufficient.'[23]

The insufficiencies of care are evident in a number of deaths, typified by that of the white American tourist **Brian Dalrymple**.[24] On 14 June 2011, 35-year-old Dalrymple came to the UK for a two-week holiday, although he suffered from schizophrenia and severe hypertension, controlled as long as he took his medication. Immigration officials refused to allow him to enter on the basis of lack of luggage and odd behaviour. He was detained at Harmondsworth for removal to the US but claimed asylum. He was held at Harmondsworth from 15 June to 27 July 2011, during which he was observed by GEO staff standing in the corner muttering to himself, urinating on the floor of his cell and throwing food. He was segregated and then moved to Colnbrook where he died from a ruptured aorta on 31 July 2011. The jury found that medical record-keeping at Harmondsworth was 'shambolic' and that despite obvious signs of distress no assessment took place during his six weeks in detention.[25]

A few weeks before Dalrymple died, on 2 July 2011, a 47-year-old Pakistani man, **Muhammad Shukat** died after suffering a heart attack in Colnbrook. An inquest jury in May 2012 recorded a highly critical verdict that found neglect contributed to his death. According to the PPO report into his death, he was transferred from Brook House (near Gatwick) to Harmondsworth on 26 May, held for nearly a month, during which time he withdrew his claim for asylum and asked for assisted voluntary return. He was moved to Colnbrook on 29 June (at 1am) and died just a few days later. While at Harmondsworth he made a complaint about the healthcare at the centre that was not followed up, staff at the healthcare unit also failed to obtain his medical records despite his written authorisation. These records 'could have provided significant information that could have assisted healthcare staff [at Colnbrook] on the morning he died'. The PPO made a number of recommendations following the investigation into Muhammad Shukat's care at Harmondsworth, in relation to healthcare and the complaints process at Harmondsworth (numerous other recommendations were made in relation to the care that he received at Colnbrook).[26]

Although IRCs are not prisons and should not be like prisons, all are surrounded by high fences and barbed wire, and Harmondsworth and Colnbrook in particular have been likened to medium-security prisons. Certainly, the use of highly inappropriate restraints is not uncommon. It took the death of an 84-year-old Alzheimer's sufferer in handcuffs and a subsequent Channel Four News report to make this public.

Alois Dvorzac was an 84-year-old Canadian with Alzheimer's who died handcuffed in hospital in February 2013 after being sent there from Harmondsworth. Little is known about his death, as an inquest has yet to be held and the Home Office has released very little information. A doctor at the centre told Channel Four News: 'This person was extremely vulnerable, he was frail, he should not have been there in the first place, let alone to be detained for such a long while.' She alerted her manager, the UKBA and the Canadian High Commission. An attempt to deport Dvorzac was abandoned and he

was declared unfit to fly. He died of heart failure after being handcuffed for five hours.[27] According to CI of Prisons Nick Hardwick, Dvorzac was one of at least two elderly, vulnerable and incapacitated detainees 'needlessly handcuffed in an excessive and unacceptable manner'. The other man, who was terminally ill, died shortly after his handcuffs were removed. The HMIP described them as 'shocking cases where a sense of humanity was lost'.[28]

In March 2014, the PPO published a *Learning Lessons Bulletin* on the investigation of fatal incidents in removal centres and complaints from detainees. He reported his disappointment that 'we have frequently had to highlight the lack of clear and effective systems to ensure that the nature of an emergency is correctly communicated, and that healthcare and detention staff working in IRCs are sufficiently trained and equipped to deal with medical emergencies'.[29]

The *Bulletin* focused on eight of fifteen deaths between 2004 and 2011 where there were concerns about the emergency response. Despite recommendations for improved emergency responses made in 2004, and again in 2011 following deaths in an IRC, three current investigations (not covered by the *Bulletin*) seemed to raise similar issues: the lack of an emergency code system, delays in calling an ambulance and healthcare staff failing to access emergency equipment quickly. The lack of progress was, said the PPO, unacceptable. Days after the publication of the *Bulletin*, on 30 March 2014, 40-year-old **Christine Case**, a Jamaican woman who had been in the UK for fourteen years, died at Yarl's Wood (run by Serco), after suffering what was reported to have been a heart attack.

Deaths shortly after release

At least four people have died shortly after being released from immigration detention, some of whom were suffering from serious illnesses and should never have been detained. There is some uncertainty about the actual figures, as such deaths following detention are not necessarily investigated by the PPO, nor is an inquest automatically held.[30] A death following release, which is currently being investigated, is that of 52-year-old **Khalid Shazad**, a Pakistani man who died of a heart attack on a train hours after being released from Colnbrook on medical grounds in March 2013.

Deaths during deportation

Deaths have also taken place during attempted deportations. These may involve both police and immigration officers or officers of private firms acting as 'escorts'. Of the deaths that we have recorded, five involve raids by immigration officials (and police officers) at residential addresses and a single death on a plane during the deportation process itself. And others have died after deportation: for example **Ama Sumani**, a seriously ill Ghanaian woman suffering with kidney failure died in Ghana three months after being deported in March 2008. And, more recently, in January 2013, **Jackie Nanyonjo** is reported to have died in Uganda as a result of injuries allegedly sustained during her deportation carried out by guards from Reliance.[31]

Only two people have died following restraint in the deportation process itself in the UK, the first was **Joy Gardner** in 1993, the second **Jimmy Mubenga** in October 2010. Both deaths, seventeen years apart, raised similar issues. Gardner died at her home following restraint by police officers and an immigration official, and Mubenga died on board a plane at Heathrow after being restrained by three guards from the private security firm G4S.

Although there have been no other deaths in the community involving restraint, there have been four other deaths following a visit by police officers or immigration officials to a person's home. People flee in fear and fall to their deaths from balconies or windows. For some people, the fear of being sent back leads to desperate measures. **Joseph Nnalue**, a 31-year-old Nigerian, died in October 1994 after falling from a balcony in a flat in Stockwell – police and immigration officials were calling at his flat at the time, acting on a tip-off. **Noorjahan Begum**, a 35-year-old Bangladeshi woman, died in March 1996 after falling 30 feet from the balcony of the flat where she was living in east London; two immigration officials had called for her at the time. **Joseph Crentsil** died in November 2001 after falling from a third floor of a block of flats in Streatham, south London. Immigration and police officers had called at the flat looking for another man. In September 2008, **Frank Odame** died after being found with head injuries below a block of flats in Woodford after police officers and immigration officers had called at 7am.

Subcontracting deportation, inspections and use of force

As stated previously, private firms have been used by the government since the 1980s to carry out deportations of failed asylum seekers – many of whom are, of necessity, unwilling to go. The use of force during deportations has been subject to a number of official investigations and reports.

In 2009 the HMIP conducted her first short thematic inspection on removals and found 'that there were considerable gaps and weaknesses in the systems for monitoring, investigating and complaining about incidents where force had been used or where abuse was alleged'. Numerous recommendations on training and monitoring in relation to deportations were made.[32]

01/09/93 JOY GARDNER (40)

Gardner died four days after going into a coma following a deportation raid. During the raid, an immigration official and five Metropolitan police officers gagged her with thirteen feet of adhesive tape and applied a body belt and handcuffs. She had come to the UK in 1987 on a six-month tourist visa, and given birth to a son. In 1990 when she married, she applied to regularise her stay on compassionate grounds, but was refused.

A deportation order was issued in 1992 but she was not located. Then, in 1993, when she had been, her lawyer was told of her proposed deportation in two letters dated 26 and 27 July. On 28 July, before the letters had even been opened or Joy had any idea of what was planned, three police officers (from the Alien Deportation Group/ SO1(3)), two uniformed local police officers and an immigration officer called early in the morning at her home in Crouch End to put her and her son on a 3pm flight to Jamaica. A struggle ensued, part of which was witnessed by her son. Joy apparently removed her T-shirt and began shouting that she would rather die than go back, and was shoved to the floor where the two local police officers sat across her legs, the female ADG officer across her midriff and another near her head. One of the ADG officers placed the body belt around her waist, her wrists were secured to the handcuffs which were in turn secured to the body belt. Her ankles and thighs were further bound with two leather belts. Thirteen feet of elastic adhesive bandage were then wrapped around Joy's head and across her mouth as she was 'still shouting or screaming'.

One ADG officer, realising something was wrong, called an ambulance. Police officers attempted to resuscitate her and when the ambulance arrived at 8.15am she still had no heartbeat. She was revived at 8.40 and arrived at hospital at 8.43 where she was placed on life support. The Home Office initially claimed that the cause of death was kidney failure but this was later revised to head injuries sustained during the struggle. A post-mortem ordered by Joy's mother found that she had died as a result of oxygen starvation. Other post-mortems also found that the lack of oxygen in combination with being gagged led to her death.

Paul Condon, Metropolitan police chief, suspended three of the officers involved and, in April 1994, the CPS charged the three ADG officers with manslaughter. At the trial the officers said that they regularly used mouth gags, body-belts and leather straps to restrain people being deported. The use of mouth-gags was not in the Police Self-Defence & Restraint Manual at the time. Their use was suspended by the Metropolitan police commissioner in August 1993 and banned by the home secretary in January 1994. All of the officers were cleared of manslaughter in 1995. Joy's mother and others have continued the campaign around her death (see Chapter 6).

Inspections in recent years have mainly examined deportations on charter flights which are usually heavy with security. For example, a charter flight on which fifty-three people were being deported to Nigeria carried a cohort of G4S staff, including 'a senior supervising officer, two assistant senior supervising officers, four coach commanders and 131 escorts'.[33] The two inspectors on this flight found that 'force and restraints were sometimes applied for longer than was necessary' and that the use of racist language indicated a disregard and contempt for the people in their care.[34] An inspection of a charter flight to Nigeria and Ghana found that handcuffs and leg restraints had been used but that handcuffs had been applied for too long in some instances and noted that recommendations about racist, offensive, inflammatory and derisive language had only been partially implemented since the last inspection.[35] Two years later, in a 2013 report on a charter flight to Pakistan (with sixty-six deportees and 124 staff), the Chief Inspector complained that 'It was hard to understand why the escorts had still not been provided with training on use of force in confined environments such as aircraft, some two and a half years after we first made that recommendation.'[36]

Inspectors also reviewed incidents involving restraint and the report recorded two incidents where handcuffs had been left on too long. In the first, in August 2013, 'a man in the Colnbrook IRC separation unit was presented to Tascor escorts already in handcuffs, which had been applied to the rear. He had a history of disruptive behaviour and was refusing to leave his cell. He physically resisted attempts to move him and refused to engage with staff, resulting in leg restraints being applied. Tascor staff moved his handcuffs from the rear to the safer front position during the journey to the airport. The detainee then refused to walk to the aircraft and was carried on, still in leg and hand restraints. In total, his leg restraints remained on for about three and a half hours, and handcuffs were removed after five hours and 20 minutes.' In another incident, in October 2013, 'a married couple was due to be removed from Yarl's Wood. However ... the woman ... was considered unfit to fly. The Home Office gave authority for the man to be removed separately. He became extremely upset at this news and insisted that either they be removed together or both remain at the IRC together. He became aggressive and hit out at staff, who applied both handcuffs and leg restraints to move him. The man became calm during the journey to Stansted and was given the opportunity to speak to his wife on the telephone. His leg restraints were removed after 45 minutes but, despite the fact that all staff reports showed that he was completely compliant after his initial outburst, his handcuffs were not removed for seven hours and 40 minutes, shortly after the plane had taken off.'[37]

It is little wonder then that the independent organisation Medical Justice found 'an alarming and

unacceptable number of injuries have been sustained by those subject to forced removals' with guards from G4S at the top of its list of offenders (followed by Wackenhut, RSI, Loss Prevention International, GSL, UK Detention Services, Serco, GEO Group Inc, Premier, API, etc). Its report examined nearly 300 cases of alleged assaults that took place between January 2004 and June 2008, 66 per cent of which were on men and 34 per cent on women. Forty-eight per cent of the alleged assaults occurred at the airport before the detainee was placed on the plane; 24 per cent on the plane before take-off; 12 per cent in the transport van on the way to the airport. The 'most common form of injury recorded resulted from inappropriate use of handcuffing, including swelling and cuts to the wrist, sometimes leading to long-lasting nerve damage. Other injuries included bruising and swelling to the face and fractures to the wrists, ribs or ankles'.[38] What these reports reveal is the casual everyday use of force, human degradation and racial prejudice inherent in the deportation process. It is revealing that 'low-level' incidents occur even when inspectors are present, so accepted have they become.

The ultimate price was paid by Jimmy Mubenga.

12/10/10 JIMMY MUBENGA (46)

Mubenga died on the floor of a British Airways plane at Heathrow, after being restrained by three guards from the private security company G4S as he was deported to Angola. Mubenga was heard to say 'I can't breathe, I can't breathe' and 'they're going to kill me', before he collapsed.

The inquest was told how he was bundled to a seat following an altercation with the three guards and then handcuffed with his hands behind his back and restrained in his seat while his head was forced down for over half an hour. The plane was readying for take-off before the G4S escorts realised something was wrong and the plane was taken back to the stand, where paramedics were called. He was found to have died by the time paramedics attended. Neither the guards nor BA staff thought to give Jimmy first aid before the London Ambulance Service arrived, despite being trained to do so.

In July 2013, the inquest jury ruled that Mubenga was unlawfully killed by three G4S guards 'using unreasonable force and acting in an unlawful manner' when they restrained him. They found that he 'was pushed or held down by one or more of the guards causing his breathing to be impeded ... [He] was pushed or held down, or a combination of the two, [which] was a significant ... more than a minimal cause of death ... The guards we believe would have known that they would have caused Mr Mubenga harm in their actions if not serious harm.'

The inquest heard much evidence on the training procedures of G4S and what guards had been told about in terms of the dangers of restraint. It is highly unusual in such an inquest for medical experts and evidence to be in such agreement. However, three eminent specialists all found that Mubenga had died as a result of cardio-respiratory failure caused by restraint.

In the wake of Jimmy Mubenga's death

The Mubenga case was something of a watershed. The campaign launched after his death, which centred around his widow but was supported by anti-racist campaigners, the organisation INQUEST, those protesting against G4S and fellow Angolans, kept up the pressure, with pickets and protests and marches to get the case noticed (most notably in the *Guardian*) and those responsible called to account. G4S's contract for escorted removals ended two weeks after the death of Mubenga in October 2010 and was awarded to Reliance Security Task Management Limited, which in August 2012 (along with Reliance Medical Services (RSM)), was acquired by Capita and in January 2013, the companies were renamed as Tascor, though G4S still provides security for some deportation charter flights.

A few months after Mubenga's inquest the coroner issued a Rule 43 report which made numerous recommendations in relation to: Detention and Custody Officers: Powers and Accreditation (the accreditation of one of the G4S officers involved in the death had run out four months earlier, so in theory, he was not authorised to escort Mubenga); Racism: Culture and Personnel (the coroner was very critical of racist text messages found on the phones of two of the guards as well as 'an unhealthy culture in G4S, and then Reliance'); Use of Force (the coroner was concerned over certain areas: scenario based training, use of control and restraint on an aircraft; handcuffing to the rear and restraint/positional asphyxia.) She was also critical of the failure to implement training nearly three years after Mubenga's death.[39] And it appears from a Freedom of Information Request that the Home Office had already been made aware of concerns over certain forms of restraint, including the use of head support from the front, in a National Tactical Response Group 2008 report entitled *Project Status UKBA Restraint on Aeroplanes*. But the report does not seem to have been acted on. Jimmy Mubenga died after methods highlighted as dangerous in the report were used on him.[40]

Ultimately, in March 2014, after the inquest, the CPS decided to prosecute the three guards for manslaughter, two years after deciding that there was insufficient evidence for a prosecution to be likely to succeed – a decision widely criticised at the time as perverse by prominent campaigners.[41] The company, however, is not to face any proceedings.[42] In December 2014 the three guards were found not guilty. Significant evidence, including about racist texts by the guards, was withheld from the court.[43]

In 2011 the UKBA requested that the National Offender Management Service's (NOMS) National Tactical Response Group conduct a review of restraint techniques used by escorts including during overseas removals. And in 2013 the Cabinet Office set up an Independent Advisory Panel on Non-Compliance Management 'to help the Home Office to adopt the best possible restraints package: one that avoids force whenever possible; one that minimises harm and maximises safety. Although no use of force can ever be entirely risk-free.' In 2014 it published its report on the new training for detention custody officers escorting those being removed from and within the UK.

'New' equipment of control, such as waist-restraint belts, leg restraints, rigid-bar handcuffs and a mobile chair were proposed for use in plane aisles on the 'most disruptive and difficult detainees' and generally only on charter flights. (NOMS had wanted the waist-restraint belt used on all detainees.)[44] But how much more safe and humane such equipment will be is a moot point. Such methods have been in use in Europe for some years and resulted in a number of deaths, including that of Khaled Abuzarifeh in 1999 in a lift at Kloten airport after being sedated, bound and strapped to a chair.[45]

And whether the new training will address the hardened culture involved in deportations remains to be seen. The endemic racism in the deportations process is mainly hidden from public view and the victims of abuse and mistreatment, often 'successfully' removed, are hardly in a position to complain.

Conclusion

The introduction of the market through the privatisation of asylum and immigration functions has resulted in a poor service, a lack of sanction and a system (characterised by re-allocating contracts) in which it is hard to call wrong-doers to account.

A number of areas of concern emerge from an examination of cases over time.

- People from vulnerable groups who should expressly not be detained, are being, thereby putting them at risk;
- The mental state of those held is not sufficiently assessed, monitored or responded to;
- The medical care provided for both physical and mental illness is grossly inadequate;
- A failure to learn from and apply lessons from previous fatalities causes more;
- The outsourcing of custodial and escort services to the private sector has led to a debasing of the detention culture including instances of day-to-day casual racism.

◆ ◆ ◆

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5. *Daily Mirror* (8 December 2003).
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7. PPO, *Inquiry into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort*, (July 2005).
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9. One Roma woman held at Yarl's Wood reported 'having had sexual contact with three male guards' and 'attempts were made to deport her within days of her informing Yarl's Wood's management of the incidents. She also claims one security guard had inappropriate relations with at least four women.' Mark Townsend, 'Detainees at Yarl's Wood immigration centre "facing sexual abuse"', *Observer* (14 September 2013) <http://www.theguardian.com/uk-news/2013/sep/14/detainees-yarls-wood-sexual-abuse>. And in 2014, a whistleblower revealed that Serco had failed to 'properly investigate a claim of repeated sexual assaults'. Mark Townsend, 'Serco whistleblower's Yarl's Wood sex claim', *Observer* (24 May 2014) <http://www.theguardian.com/uk-news/2014/may/24/serco-whistleblower-yarls-wood-pressure-immigration>.
10. See parts 2 and 3 of Frances Webber, *Borderline Justice: the Fight for Refugee and Migrants Rights* (London, Pluto Press, 2012).
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12. *Hansard* HC (Vol. 946, 16 March 1978), col. 292-3W <http://hansard.millbanksystems.com/written_answers/1978/mar/16/detention-centres-harmondsworth-and>.
13. GEO Group press release, 'The GEO Group U.K. subsidiary signs contract for the management of the Harmondsworth Immigration Removal Centre in England' (28 January 2009). <http://phx.corporate-ir.net/phoenix.zhtml?c=91331&p=irol-newsArticle&ID=1249237&highlight=>
14. In recent months, Serco and G4S have been criticised in government inquiries into various contracts. Serco and G4S have held the contract to house asylum seekers across most of the UK since January 2013, with G4S and Serco operating in four of the six areas (the other contractor being Clearel). A National Audit Office investigation found that, in some areas, there were delays of three months as 'G4S and Serco struggled throughout preparations for and during transition to establish a robust and reliable supply chain'. These same contracts have come under scrutiny from the Home Affairs Committee; its chair, Keith Vaz, commented: 'We were alarmed to discover that thousands appear to be living in squalid run-down housing as part of the COMPASS contract supplied by the private contractors G4S, Serco and Clearel. These companies must be held accountable and deliver a satisfactory level of service. It is unacceptable that in 21st century Britain thousands of people are forced into destitution due to the inefficiencies of the system.' National Audit Office, *COMPASS contracts for the provision of accommodation for asylum seekers* (January 2014) <http://www.nao.org.uk/report/compass-contracts-provision-accommodation-asylum-seekers/>; Home Affairs Committee, *Asylum* (October 2013) <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/news/131011-asylum-rpt-published/>. Many of these companies are also major providers of other government services. G4S operates the Work Programme (which attempts to help people get and stay in work) in some areas in the UK, and Serco operated the 'Boris Bikes' scheme in London (a contract which it lost in July 2014). In November 2013, the Serious Fraud Office commenced a criminal investigation into G4S and Serco electronic monitoring contracts after it was revealed that the firms had overcharged the Ministry of Justice and charged for work that they had not completed. In March 2014, G4S agreed to repay the government £108.9 million plus VAT. See National Audit Office, *The Ministry of Justice's electronic monitoring contracts* (November 2013) <http://www.nao.org.uk/report/the-ministry-of-justices-electronic-monitoring-contracts/>.
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5 | After death – the struggle continues

FOR MANY FAMILIES, the death is not the end of the tragedy, but the beginning of a drawn-out agonising process. Bewildered by sudden grief, desperate to understand how and why their loved one died so as to find some sort of closure, they are also up against all those agencies which they might have thought were there to help them. Families are in the perverse situation that they are reliant on the institutions where their loved ones died in fraught circumstances to tell them what happened. Almost every family has had to learn the hard way that they are up against agencies and systems which close ranks to protect their own. This is compounded by the fact that most of the affected families will be without the resources to purchase the kind of professional advice and assistance to see them through what (they are yet to know) may be months, years or decades of striving to get the truth about a death, let alone have someone held responsible for it.

It is precisely because of this complete lack of power that for over thirty-five years families have fought, together and for one another, for a more open and accountable system of investigation and accountability. It was the campaigners around **Blair Peach**'s death in 1979 who fought to empower families in the inquest system – leading to the setting up of the organisation INQUEST in 1981 to assist families and help provide them with legal representation at inquests. In 1997, after the deaths of Leon Patterson, Brian Douglas and Shiji Lapite (among others), the United Families and Friends Campaign began as a self-help group for families to support each other, to remember and keep in the public view the issue of deaths in custody. And after the fight to demystify the inquest system, the next station of the cross was to fight for an independent authority to oversee and in some cases directly investigate complaints against the police and prison guards. The final battle, and the one that absorbs much of the energy of families today, is to get the Crown Prosecution Service (CPS) to accept the level of evidence accepted as conclusive by an inquest jury, as justifying charges against those held responsible for a death in an unlawful killing verdict.

This long struggle has been fought, not only to find out what really happened to loved ones, and to unveil the racism and brutality that is stamped through custodial institutions, but also to change the perverse situation whereby the police, often the perpetrators of an injustice, have the power to act as arbitrator and prosecutor.

It is hard to accept as natural justice a situation where a jury can reach a verdict which implies culpability by officers, who go on to face neither criminal prosecution nor internal disciplinary proceedings (e.g. suspension, fine, demotion or dismissal from the force) for their conduct. Not only do families come away from such situations feeling utterly betrayed by British justice, but it sets a terrible precedent as to what is acceptable behaviour for our 'guardians'.

Family liaison

For the families of those who die in custody, the notification process, the phone call or police officers on their doorstep, is the start of a long and fraught relationship with agencies of state that are in some instances actually responsible for the death of their loved ones. This initial notification process has been the occasion for a number of complaints. In the Azelle Rodney case, for example (see below), it was some twenty-four hours before the family were officially informed. Worse, in some cases, media releases by the police following a death have misinformed the public about the circumstances of a death or the character of the deceased. The death of Mark Duggan saw information from the Independent Police Complaints Commission (IPCC) widely circulated which wrongly indicated that he had fired on police officers. The death of Roger Sylvester led to an impromptu press conference where he was falsely branded a drug user. Jean Charles de Menezes was dubbed a suspected terrorist who had refused to obey police orders to stop.

The inquest

Preparatory problems

By law a coroner[1] must investigate every suspicious death,[2] and a jury must be empanelled in cases of death in custody. Within a few days of the coroner

being notified, an initial hearing takes place where the deceased is identified and the proceedings are adjourned for investigations[3] and inquiries to be conducted. Before the inquest proper proceeds, the coroner releases the body to the family so that a funeral can take place. Sometimes coroners can give authority for burial at the initial hearing, but in controversial cases, where separate post-mortems are performed on behalf of different interested parties such as the family and/ or officers involved, funerals can be severely delayed. The family of Kingsley Burrell, who died in March 2011, had to wait for over sixteen months to hold his funeral. And in another case a family was given the wrong body to bury. It was only discovered in November 2011 that Christopher Alder, who died in 1999, had not been buried, as the family thought, in 2000, but instead, his body had been mislabelled and stored in a mortuary in Hull.

Before the inquest takes place various hearings (pre-inquest reviews) are held, where for example interested parties are identified and notified of the proceedings, witnesses are identified, and evidence disclosed (relevant statements and reports). The work of the charity INQUEST is invaluable in providing families with access to advice and lawyers with experience in the field. The various interested parties, through their legal representatives, will make representations to the coroner about what evidence is called and what the inquest will explore. Most families have to wait for some time before an inquest can take place, often years. The wait for information is particularly difficult for families who are grieving.

Disclosure and openness

Fighting for disclosure to families of all the information available is part of a long and ongoing struggle. It took Celia Stubbs over thirty years to obtain access to the report of the internal inquiry into her partner Blair Peach's death, conducted for the Met police by Commander John Cass.[4] During the inquest, while the coroner and lawyers for the police had the report (which found that he had been killed by the police, and recommended prosecuting three officers who had tried to conceal evidence from the inquiry), neither Peach's family nor the jury had access to it. Little wonder that in May 1981 the jury reached a verdict of misadventure. Since that time, the right to have disclosure of all relevant documents, and to ensure that inquests are totally accessible to the public and press, has been part of a political campaign. But despite the work of families and INQUEST, and a recommendation for 'advance disclosure of evidence and documents' in the 1999 Macpherson Report (on his inquiry into the 1993 racist street murder of Stephen Lawrence),[5] disclosure of all the evidence to families remains a problem.

They are not always given advance copies of Prison and Probation Ombudsman (PPO) and IPCC investigation reports (see below) as they should be. Sometimes they have they been forced to take legal action to ensure the disclosure of evidence. Following the controversial shooting deaths of Azelle Rodney in 2005 and Mark Duggan in 2011 the police withheld or redacted evidence, claiming secrecy for operations related to serious crime or because of their use of intercepts or informants.[6] For the epic legal fight of Rodney's mother, Susan Alexander (with the support of lawyer Daniel Machover), after the inquest was halted in September 2007 because of the supposed need for police to secret evidence, see Chapter 6.[7]

Mark Duggan's family also underwent a long struggle for disclosure of police evidence. The original inquest was halted as the evidence was deemed too sensitive to be heard by a coroner. Ultimately, a crown court judge began a new inquest in September 2013, sitting at the Royal Courts of Justice with a jury whose members were granted anonymity, and all the evidence seen by the jury (including contemporaneous police documents, many redacted) is on the inquest website.[8]

Unequal forces

At the start of the inquest proper, a jury is sworn in and the coroner explains the proceedings, usually along the lines of 'We are here to find out who the deceased was, when and where the deceased died, and how and in what circumstances.' Always emphasising 'This is a fact-finding exercise – which means it is not adversarial and we are not here to apportion any blame.' But proceedings invariably do end up being adversarial in cases involving a death in custody, as lawyers for the family have to challenge an official version of events and lawyers for police/prison officers seek to prevent certain lines of questioning. Lawyers representing the interests of the private company running a detention centre or prison, for example, or acting for individual police or prison officers, will robustly challenge any criticism of their clients (as is their right). The family has in effect to fight many levels of state institutions to get at the truth: the individuals involved in the death; the 'local body' involved (police force or prison establishment); and the institution with responsibility for the 'local body' (Prison Service, Home Office or private corporations such as G4S and Serco).

Families often have to contend with a large number of other 'interested parties'. For example, at the 2013 inquest into the death of Jimmy Mubenga (see Chapter 4) there were seven interested parties in addition to Mubenga's family: the three G4S guards involved in his death, G4S, the Home Office's UK Border Agency, British Airways and the London Ambulance Service. There were also seven interested

parties at the 2014 inquest into the death of American Brian Dalrymple, in Colnbrook removal centre.

Funding and access

One of the major challenges for families is to get legal representation. Lawyers for individual police officers are funded through public funds because 'It is important that police officers should be able to carry out their duties in the confidence that their police authority will support them by providing financial assistance in legal proceedings taken against them and progressed by them, if they act in good faith and exercise their judgment reasonably.'[9] Prison officers' legal costs would be covered by their union, the Prisons Officers Association if they were represented separately from the Ministry of Justice. Lawyers acting for the Prison Service, Home Office or a police force are also paid from public funds.[10]

Families, on the other hand, must either pay for their own legal representation or go through the often lengthy and fraught process of obtaining legal aid funding, which is means-tested. The family of Cherry Groce, who died in April 2011 after being shot during a police raid of her Brixton home in 1985 and paralysed, had to launch a public campaign following the refusal of legal aid for the inquest in 2014. A petition, which garnered 134,000 signatures, led to a review and ultimately a reversal of the decision.[11]

In response to evidence submitted to the inquiry, the Macpherson Report recommended that 'consideration be given to the provision of Legal Aid to victims or the families of victims to cover representation at an Inquest'.[12] But representation at inquests has been removed from the scope of legal aid, although families can be eligible for 'exceptional funding', which is not automatic and subject to means testing.[13] Without the automatic right to public funding that police and prison officers have, families begin the fact-finding process at a disadvantage.

It is not just lack of money that puts families at a disadvantage. Immigration laws can make it nigh on impossible for family members to attend. Lawyers acting for the mother of a Zimbabwean man who died in Belmarsh prison had to go to the High Court twice in order for her to be granted a visa so she could attend the inquest.[14]

Verdict

An inquest generally culminates in a verdict, reached by the jury after listening to all the evidence. Verdicts will generally be one of the following: natural causes, killed himself while the balance of his mind was disturbed (suicide), misadventure, lawful killing, unlawful killing, open verdict or a narrative verdict (where a longer explanation is given).[15] In some cases, certain verdicts are not left before a jury as they may not apply or the coroner rules that there is not enough evidence to support them. Unlawful killing verdicts are the most controversial, and for a jury to record such a verdict, illegality has to be proved beyond reasonable doubt. (The same applies to a verdict of suicide.) An unlawful killing verdict usually means that the CPS has to consider bringing charges against those involved, if it hasn't already done so.

Changes to the inquest system

It should be noted that during the period of our research, changes were made to the inquest system. Under the Coroners and Justice Act 2009, which came into force in July 2013, a chief coroner was appointed, to lead the system and to set national standards through guidance, training and monitoring. The chief coroner has issued fourteen separate guidance notes for coroners as well as a comprehensive guide to the changes in the system. He said, 'Inquests will be heard earlier, usually within six months. Families will receive information earlier and will have greater access to documents and evidence. Bodies will be released earlier for burial or cremation. Fewer inquests will be needed as a result of early investigation. And there will be a special emphasis upon coroners reporting to prevent future deaths.'

The Rule 43 procedure which allowed coroners to report matters of concern and to make recommendations to relevant bodies, which had to respond within a fifty-six day timescale, has become a statutory duty, in appropriate cases, to issue a Prevent Future Deaths (PFD) report to individuals or organisations with the power to take action. The chief coroner publishes six-monthly reports summarising the numbers of PFD reports, who they were addressed to, the recommendations they contained and whether the organisation responded, and he can review and consult on areas of concern and make further recommendations.[16] But, unfortunately, there is no follow-up mechanism to ensure that recommendations are implemented and lessons learned, and, as we showed in previous chapters, especially in relation to deaths in prison and immigration detention, it is woefully obvious that recommendations are just not carried out, lessons are not taken from previous tragedies and deaths follow a pattern.

Independent oversight

Deaths in prison/detention

As already intimated in the chapters on prison and detention centre deaths, not only families, but also official bodies have found that deaths follow a pattern, indicating that recommendations to prevent further deaths are not being implemented and lessons not being learnt. The PPO usually investigates deaths in prisons, young offender institutes and

immigration centres, and some deaths shortly after release from detention.[17] The investigator's report, based on interviews with those involved and relevant documentation, with recommendations to prevent further fatalities, is sent to interested parties for their comments. Institutions often object to criticisms, leading to observations being rephrased or even omitted, and the reports are ultimately published, in anonymised form, after an inquest.

Recommendations in PPO reports can be accepted in total or part by the relevant parties (an individual prison establishment or the Prison Service) and action plans put in place to ensure their implementation. If the procedures already exist to cover recommendations, then staff simply have to be reminded of existing policy. However, because of delays in holding inquests and publishing PPO reports, the Prison Service can usually respond that the necessary steps have been taken to ensure similar mistakes are not repeated. But they are – again and again.

The same pattern is seen with deaths in immigration removal centres. PPO recommendations have to be repeated again and again as the same mistakes are repeated again and again (see Chapter 4). In 2006, the Chief Inspector of Prisons issued an inspection report on Harmondsworth removal centre that was 'undoubtedly the poorest report we have issued'. 'Most worryingly', she reported, 'a so-called action plan, to deal with problems identified by the inquiry into [a] recent self-inflicted death, had been shared with neither the suicide prevention team nor the staff in the centre. It was a purely bureaucratic exercise which had had no impact on the centre's practices'.[18] Another HMIP report, on Wormwood Scrubs, observed that the PPO 'had made repeated recommendations concerning suicide and self-harm which had yet to be implemented.'[19]

Investigating deaths in police custody: from the PCA to the IPCC

The way that the authorities deal with complaints over heavy-handed policing of Britain's black community has been a highly contentious issue since the 1960s. And the fact of the police investigating themselves when a complaint is made has been particularly contested.

During the 1990s, the Police Complaints Authority (PCA) was responsible for investigating deaths in custody. (In fact it did not carry out investigations itself but appointed other forces to carry out investigations under its supervision.) But dependent on the police to find evidence of misconduct (compounded by the police disciplinary system whereby each force was responsible for dealing with its own officers' misconduct) the PCA's lack of real independence came in for frequent criticism. And no more so than in its handling of controversial deaths in custody. For example in the case of Brian Douglas, who died from a blow to the head from a police baton (see Chapter 2), no officer faced disciplinary charges, although even the High Court questioned whether officers' evidence was 'wholly satisfactory' and pathologists queried the police version of events. The inquest verdict was death by misadventure. In the case of Shiji Lapite's death in a police neck hold in 1994, despite the unlawful killing verdict and the coroner referring the case to the DPP for a possible manslaughter charge, the PCA decided not to recommend disciplinary action against the officers involved. Eventually in 1997, after the High Court quashed the DPP decision not to prosecute, a judicial inquiry was set up into CPS decision-making in relation to deaths in custody, and the PCA admitted failings.[20] The United Families and Friends Campaign was instrumental in carrying forward the family campaigns around the conduct of the PCA and the DPP in relation to both these deaths.

BME and other campaigners' concerns were now so public that even Sir William Macpherson was moved to recommend that 'the Home Secretary, taking into account the strong expression of public perception in this regard, consider what steps can and should be taken to ensure that serious complaints against police officers are independently investigated. Investigation of police officers by their own or another Police Service is widely regarded as unjust, and does not inspire public confidence.'[21]

The Independent Police Complaints Commission

The PCA had had its day. In its place the Independent Police Complaints Commission (IPCC) was established in 2004 to oversee the police complaints system in England and Wales and investigate the most serious cases, including deaths in police custody (which must be referred to it by the police).

Independence: We were told that this was now a truly more independent body, as officers were no longer investigating one another. But in a sense they are. Although the IPCC does not employ serving police personnel, it does employ ex-police officers and ex-police civilian staff. According to its most recent annual report, during the financial year 2012/13 it employed forty-four ex-police officers and forty-one ex-police civilian employees (21 per cent of all staff); of the ninety-five staff in the roles of Investigator/ Deputy Senior Investigator/ Senior Investigator, forty-six were ex-police officers or ex-police civilian employees (48 per cent of the total).[22] It should be noted, however, that IPCC commissioners,


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CLOSE DOWN
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REFUGEES ARE NOT CRIMINALS
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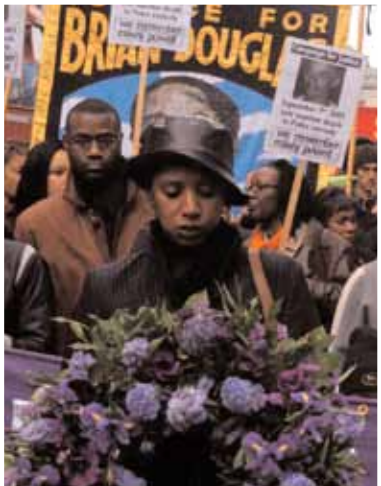
KENNY
PETER
SERGEY
BARNUYCH
MANUEL
BRAVO


RIP
PCC


Robertas Grabys (24.1.03)
Mikhail Boyarchuk (31.1.03)
Nariman Tahamasbi (25.2.02)
Beverley Fowler (2.10.02)
Lin Jim Wu (5.5.03)
Mohammed bin Dahri (20.10.03)
Liang He (10.11.03)
Sergey Barnuych (19.7.04)
John Kanga Manzoma (15.10.04)
Kenny Peter (7.11.04)
Ramazan Kumluca (26.6.05)
Manuel Bravo (15.9.05)
Tran Quang Tung (23.7.04)
Berekt Yohannes (19.1.06)
IMMIGRATION DETAINEES WHO
TOOK THEIR OWN LIVES
IN MEMORIAM


MARK
DUGGAN
CRAIG'S
COURT SW1
FAMILIES AND FRIENDS CAMPAIGN
ORE DEATHS IN CUSTODY




WHO KILLED
MY GRANDSON?
IN NOTTING HILL
POLICE STATION


ANSWERS
NOW!
ANSWERS
NOW!
STOP RACIST
BRUTALITY NOW
NO MORE
DEATHS
IN POLICE
CUSTODY
STOP RACIST
BRUTALITY NOW

who oversee investigations, must never have been employed by the police.

Investigation:[23] Over the years, many families – including the family of Christopher Alder, and, most recently the family of Sean Rigg (see below) – have levelled very similar criticisms at the IPCC, in terms of the failure to secure evidence (CCTV footage, notebooks and physical evidence) in the 'golden hour' (the period immediately following the death), and have repeated criticisms previously made to the PCA, such as failure effectively to question the police version of events and inability to reflect true independence and accountability.

Competence: A major criticism of the IPCC relates to its lack of teeth and its failure to effect any real change. Its remit is limited: it cannot bring disciplinary proceedings against officers, and cannot initiate prosecutions; if evidence suggests criminality it can send the file to the Crown Prosecution Service – whose invariable response, as we show below, is 'insufficient evidence to prosecute'. Official authorities were critical too: the National Audit Office in 2008 criticised the IPCC for its lack of quality control, external scrutiny and failure to see that recommendations were acted on;[24] the Home Affairs Committee was concerned as to whether investigations of the police were rigorous enough and recommended a statutory power to require a police force to respond to its findings – which became law in 2014.[25]

Key cases

The IPCC's bungling was thrown into relief in two recent cases – the deaths of Mark Duggan and Sean Rigg (see Chapter 2). It is perhaps a moot point, but the riots of August 2011 might never have taken place had the IPCC acted more swiftly and sensitively in informing the Duggan family and calming the immediate community disquiet. There appears to have been a complete breakdown of communication between the IPCC, local family liaison officers and the Duggan family over Mark's death on 4 August.[26] Then on 6 August, when the family and local people marched to Tottenham police station to discuss what had happened, no one from the IPCC made themselves available. It was the IPCC, too, that erroneously (and provocatively) put out a statement to the effect that Duggan had fired first at the police.[27]

The limitations of the IPCC were also brought into sharp focus in the case of Sean Rigg. The IPCC refused to contemplate the possibility that Sean's death was suspicious or that 'officers could have acted with malice or neglect despite there not being any explanation why a physically fit person should collapse and die within minutes of coming into contact with officers'.[28] His family were told that they could not examine his body and the scene of his arrest was not secured – a failure that has occurred in other cases, implying an assumption that no crime had been committed. It was the family who ensured that vital CCTV evidence was collected, and their constant questioning that led eventually to the damning critical narrative verdict at the inquest about the conduct of the officers involved, raising questions about the quality of the IPCC's investigation.

The mishandling of Rigg's death led the IPCC to commission an independent review of its original investigation. The Casale review, a highly critical report, recommended that the case be reinvestigated to ascertain 'whether there is potential misconduct in respect of the actions of the police officers involved'. It also made numerous recommendations about the conduct of IPCC investigations.[29] As a result, the IPCC's original findings on the death of Sean Rigg were set aside and a new investigation commenced in December 2013. In a new departure for the IPCC, in June 2014, it served notices of investigation on five officers involved in the arrest, restraint and detention of Sean Rigg, making arrangements to interview the officers under criminal and misconduct caution.

More than that, under pressure from Rigg's sister, one of the implicated officers was suspended in order to prevent his leaving the force, which would have given him immunity from investigation. It emerged that thirty-eight police officers in England and Wales had left the service in the past four years, avoiding inquiries into their conduct and possible disciplinary action.[30] A recommendation in the Macpherson report, that disciplinary proceedings should be available against officers for at least five years after their retirement, has never been implemented.[31]

A new broom?

The arrival of Dame Anne Owers (who previously headed the prisons inspectorate where she earned a reputation for fierce independence) as chair of the IPCC in February 2012, has led to some significant changes. Under her leadership, could the IPCC become a critical voice from within the establishment?

In 2012, she ordered a review of the organisation's investigation of deaths in custody in order to be 'confident that we are carrying it out thoroughly, robustly and fairly'. She initiated the review following 'criticism and concerns about the approach, timeliness and thoroughness of some of our investigations, particularly those into deaths following the use of restraint or force', recognising the 'need to make changes to respond to those criticisms and take steps to ensure consistency and quality.'[32] The review's findings, published in March 2014, are similar to those in the Casale review, with numerous recommendations for the conduct of investigations, many of which, if implemented, could lead to more confidence in the police complaints process.

The Crown Prosecution Service

The struggle to reform the inquest system was significantly advanced with the setting up of INQUEST, and its campaigning. The struggles of families with the IPCC also seem to be bearing some fruit. The institution that now appears to be families' largest stumbling block is the Crown Prosecution Service.

The CPS was set up in 1986 following condemnation of the system in which police both investigated and prosecuted offences. The power to prosecute was taken from the police and the CPS' role was defined as 'to prosecute criminal cases investigated by the police in England and Wales'. But the setting up of an independent prosecution service did not bring about dramatic changes, particularly in cases involving deaths in custody. Until 2003, police retained responsibility for bringing charges, and even after this responsibility was transferred to the CPS, it was given no power to direct the police to investigate, or to pursue a particular line of inquiry or look for particular evidence. The CPS remains reliant on the evidence submitted by the police when deciding on a prosecution. It is obvious that in cases of controversial deaths in custody, where police may be implicated, the close relationship between the two bodies is unhealthy and unfortunate.

What most families want is for those responsible for their loved one's death to be held accountable and prosecuted to conviction – but this is so rare as to be almost unheard of. Despite a number of unlawful killing verdicts in inquests over the last twenty years, not one police or prison officer has been successfully convicted of criminal charges by a court for involvement in a BME death in custody.

The last time a police officer was successfully convicted following a death in custody was after the death of David Oluwale, whose body was dragged from the River Aire in Leeds in 1969 – and that only after a fellow police officer broke ranks about the way officers were systematically harassing and beating up this homeless man. Ultimately, in November 1971, an inspector and a sergeant were found guilty of three assaults in the months leading up to the death (after manslaughter charges were dropped on the order of the judge).[33] They were sent to prison for three years and twenty-seven months respectively. Even in this case, though, the officers were not actually convicted of involvement in Oluwale's death. Statistically speaking, a police officer is more likely to be prosecuted (and convicted) for cruelty to an animal in their care than to be charged (let alone convicted) in connection with the death of a person in their care.[34]

According to figures from INQUEST,[35] since 1991 there have been thirteen unlawful killing verdicts regarding people from all communities who died in custody. Of these, twelve were recorded in respect of deaths of people from BME communities, three of which were overturned following further legal action.

Of the twelve BME cases we have examined where an unlawful killing verdict was recorded only two have so far led to criminal trials - of five police officers involved in the 1998 death of Christopher Alder (see Chapter 2) and of three G4S officers involved in the 2010 death of Jimmy Mubenga (see Chapter 4); in both cases leading to acquittals. A trial is pending following the unprecedented decision to prefer a murder charge against the ex-police officer (named as Anthony Long) who killed Azelle Rodney (see Chapter 6).

Charges were brought in three further cases not involving unlawful killing inquest verdicts – relating to the deaths of Joy Gardner, Mikey Powell and Michael Bailey. No inquest was held into the 1993 death of Joy Gardner, but manslaughter charges were brought against the officers involved in her death. The officers were cleared in 1995 (see Chapters 4 and 6). In the case of Mikey Powell, who died in 2003, officers were charged before the inquest was held. In January 2005, the CPS charged ten police officers: eight with misconduct in public office and two with dangerous driving and common assault. The trial began in May 2006 and in August the jury acquitted the officers of misconduct and common assault, and were unable to reach a verdict on the dangerous driving charges, which were not pursued.

The death of Michael Bailey in 2005 (see Chapter 3) led to charges of manslaughter by gross negligence and perverting the course of justice against four Global Solutions Ltd. staff from Rye Hill prison. In April 2007, they were acquitted.

Inquiries and critics

Growing disquiet over the CPS' failure to prosecute in a number of controversial cases in the 1990s led to legal challenges, and in July 1997, Gerald Butler QC was appointed to conduct an inquiry into how the CPS had handled the cases of Richard Joseph O'Brien and Shiji Lapite[36] (who died in police custody in April and December 1994 respectively). The inquiry examined the decision-making process and how material was prepared and presented and the process and quality of casework decision-making in death in custody cases.[37] In his final report, published in August 1999, Butler concluded that the decision-making process within the CPS was 'inefficient and fundamentally unsound'. No one involved in the process, up to and including the DPP herself (at that time Dame Barbara Mills QC),[38] accepted responsibility for the decision not to prosecute. He also expressed concern about the failure to prosecute the officers involved in the death of Brian Douglas. He made six recommendations on how decisions on

prosecuting should be made in death in custody cases and on training of CPS staff.

From the mid-1990s onwards, the anger of BME families at their inability to get justice for their loved ones who died in custody, and the campaigning action they were being forced to take, was being recorded by film-maker Ken Fero of Migrant Media (see Chapter 6). His film *Injustice*, which examined black deaths in custody and families' campaigns for justice, had a huge impact when it was released in 2001 after seven years in the making.[39] Police attempts to prevent it from being shown backfired as the film attracted more publicity, the *Guardian* called it one of the most powerful films ever made in this country, and eventually the CPS asked to see it. The then attorney general, Lord Goldsmith QC, with ministerial responsibility for the practices of the CPS, attended the screening,[40] and shortly afterwards announced a review of CPS decision-making in deaths in custody cases, saying he had become 'acutely aware of the profound impact on families' of failure to prosecute, their 'disillusion' and 'concern that justice has not been done'.[41]

The review, published in July 2003, acknowledged the lack of confidence in the decisions that had been made, and although he found no evidence that previous CPS decisions had been incorrect and decided against introducing any appeal process or external oversight of CPS decisions, he did announce a package of measures to speed up decision-making, increase the transparency of the process and involve families more.[42] He also observed that although an unlawful killing verdict did not automatically indicate that there was sufficient evidence for a criminal prosecution, a decision not to bring a prosecution called for 'a high degree of explanation'.[43] (Later that year, the Criminal Justice Act transferred the responsibility for charging suspects from the police to the CPS, in a further reform of the criminal justice system.)

Despite these criticisms, reviews and recommendations, the situation has remained unchanged for the families of most of those killed by the state. It still takes an inordinate time for the CPS to make decisions on prosecutions. The agonising delays have become a campaigning issue for families and for the United Families and Friends Campaign. It took the CPS nine years to decide to prosecute the killer of Azelle Rodney, described by his mother, Susan Alexander, as 'intolerable'.[44] (See Chapters 2 and 6.) Rodney's family joined Jimmy Mubenga's, who waited nearly four years for a prosecution decision from the CPS, and the families of Habib Ullah and Sean Rigg, still waiting for a decision six years after their deaths, at a demonstration in August 2014 outside the CPS offices to protest the delays.[45] They had held a similar protest in December 2013,[46] when a document was produced about six families waiting endlessly for a decision.[47]

There is still, it seems, an unwillingness to put a homicide case before a jury. The standard response given to families still seems to be 'insufficient evidence to prosecute'. These pronouncements ring particularly hollow at a time when sufficient evidence is frequently found to proceed against young members of BME communities who are charged under joint enterprise laws for homicides they had no direct part in (a number of people have been convicted on the most flimsy of evidence under the doctrine of joint enterprise).[48] Most families feel that cases involving deaths in custody should at least be put before the courts and a jury allowed to test the evidence.

Corporate manslaughter and health and safety prosecutions

In September 2011, following a lengthy campaign by bereaved families, INQUEST, Justice, Liberty, the Prison Reform Trust and others, the death in custody provisions of the Corporate Manslaughter and Corporate Homicide Act 2007 came into force, providing the CPS with a new tool for accountability. Police forces, the Prison Service, the Home Office and private contractors like G4S could be prosecuted, and face an unlimited fine, for gross and fatal breaches of the duty of care towards those affected by their activities, arising from failures in senior management. However, corporate manslaughter charges have yet to be used against any government body following a death in custody.

Another development has been the prosecution of chief constables under the Health and Safety at Work Act 1974, which requires employers to ensure that public safety is not endangered by employees' actions. Again, the penalty is an unlimited fine. Two chief constables have been prosecuted under the Act over police shootings – of Jean Charles de Menezes and Anthony Grainger.[49] There is some concern that the CPS might take the 'softer' option of prosecuting under health and safety legislation where a corporate manslaughter charge would have been a more fitting response.

2014: a year of change?

In the last six months, the CPS has announced that officers will face prosecution in two controversial cases where unlawful killing verdicts were recorded. In March 2014, the CPS announced that three G4S officers were to be charged with the manslaughter of Jimmy Mubenga, although it found insufficient evidence to prosecute G4S for corporate manslaughter.[50] This decision came a year after the inquest into his death recorded a verdict of unlawful killing, and two years after an earlier decision (in July 2012) not to prosecute the officers involved. The men

were tried and acquitted in December 2014.

Then, in July 2014, the CPS announced that E7, (since named as Anthony Long), the firearms officer whose shots killed Azelle Rodney in 2005, was to face a charge of murder.[51] (See Chapters 2 and 6). This reversed an earlier decision in July 2006 that there was 'insufficient evidence to disclose a realistic prospect of conviction against any officer for any offence'.[52] With new evidence from the judge-led inquiry into his death in July 2013 leading to an unlawful killing verdict, the IPCC had asked the CPS to review the evidence again.[53]

But fifteen years after Sir Gerald Butler's advice, prosecutions remain few. Other families have been left disappointed by the CPS' failure to bring charges against those involved in the deaths of their loved ones. In July 2014, the CPS announced that no one was to be prosecuted for the death of Kingsley Burrell: there was insufficient evidence to charge any of the four police officers, two West Midlands Ambulance Service technicians, three nurses and three doctors for manslaughter, assault or wilful neglect of a mentally disordered patient.[54] In August 2014 the CPS also announced that no one was to face charges following the death of Habib 'Paps' Ullah.[55] The CPS had considered charges of manslaughter by gross negligence, misconduct in public office, perjury and perverting the course of justice against five Thames Valley police officers and a Police Federation solicitor who had advised the officers.

What more can families do?

Blind-sided, stymied, defeated, where do families turn?

An unsatisfactory inquest verdict can be challenged through judicial review – but families are once again at a disadvantage. As well as finding legal errors in the coroner's handling of the case, they will need funding for the challenge – private or through legal aid – and recent changes have made the process more difficult and expensive.[56] The process is often painfully slow, and the courts are reluctant to overturn coroners' decisions refusing to allow juries to consider unlawful killing or neglect. (It is easier to have an unlawful killing verdict overturned, because of the stringent burden of proof in such cases, and three such verdicts have been overturned since 1991.) The pain felt by Wayne Douglas's family at his death in police custody in 1995 was amplified by their unsuccessful attempt to quash the coroner's refusal to leave an unlawful killing verdict to the jury and its subsequent verdict of accidental death, particularly when the judge referred to the additional expense of a new inquest.[57] The family of Keita Craig, a vulnerable 22-year-old who hanged himself by his shoelaces in Wandsworth prison in February 2000, had more success: the coroner's refusal to allow the jury to incorporate neglect in its verdict was successfully challenged in the High Court in 2001 and a new inquest held.

The only other way to challenge a bad inquest verdict is to persuade the attorney general to apply for a fresh inquest by presenting compelling new evidence. This is, if anything, an even tougher challenge, although it was surmounted by the families of the ninety-six who died at Hillsborough in 1989 following a marathon twenty-two year campaign. In December 2012, the inquest verdicts of 1990 were quashed on the attorney general's application, and fresh inquests started in March 2014.[58]

The IPCC, as a decision-making body, can be judicially reviewed, and the family of Olaseni Lewis (see Chapter 2) successfully challenged an IPCC decision that no officer was at fault for his restraint death in 2010. A CPS decision not to prosecute can be challenged by judicial review too, but once again families face the problem of funding, on top of that of finding legal error in the decision. And the fact that the courts cannot order the CPS to prosecute but can only order it to retake the decision can make a successful challenge seem a pyrrhic victory. There were successful challenges to CPS refusal to prosecute over the deaths of Shiji Lapite in 1994 and Alton Manning in 1995 – but in each case, after reconsideration, the CPS again decided not to prosecute. (However, the families' battles were not in vain; the challenge in Lapite's case led to the Butler review of CPS decision-making, while Alton Manning's sisters won a ruling from the Court of Appeal that the CPS had to give detailed reasons for a decision not to prosecute in death in custody cases where the inquest had delivered an unlawful killing verdict.[59])

Families can also take civil actions against the individuals or institutions involved in the death – although legal aid is not available for civil actions for damages. As a final resort, if domestic remedies have been exhausted, there is the European Court of Human Rights – a route taken by the families of Christopher Alder and Azelle Rodney, but one which is again painfully slow and uncertain and, in the early stages at least, unfunded.

In the end, many families rely on the mutual support provided by the United Families and Friends Campaign (UFFC) and the exertions of INQUEST for their campaigning, to get to the truth and to expose the institutional inhumanity and lack of care behind their loved one's death – a task that often looks endless and hopeless. For BME families, the fight against institutionally racist and secretive systems and structures is long, and is far from won.

What has been borne out in our research, though, is that it has been the family campaigns, in the public and legal arenas, that have led to lasting

change. There is no doubt that the reforms to the coroners' system, in particular the appointment of a chief coroner and the strengthening of the coroners' reporting duties, the extension of corporate manslaughter liability to deaths in custody, the reforms to police complaints and the greater accountability of the CPS, are owed in no small measure to the families who have fought for justice for their sons and brothers.

A luta continua.

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References

1. Judicial officers who are legally and/ or medically qualified, coroners are appointed by local authorities to inquire into deaths where the body is found in the relevant authority's area.
2. That is one where the cause of death remains unknown after a post-mortem, or where the death appears violent or unnatural, or where the deceased died in custody.
3. By the Independent Police Complaints Commission (IPCC) for deaths in police custody, and the Prisons and Probation Ombudsman (PPO) for deaths in prisons and immigration removal centres (IRCs). See below.
4. See David Renton, 'The killing of Blair Peach', *London Review of Books* (Vol. 36, no. 10, 2014). <http://www.lrb.co.uk/v36/n10/david-renton/the-killing-of-blair-peach>
5. *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson Of Cluny,* Recommendation 42 (February 1999). <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf>
6. Helen Shaw, 'Azelle Rodney inquiry must answer tough questions about his death', *Guardian* (4 September 2012). <http://www.theguardian.com/commentisfree/2012/sep/04/azelle-rodney-inquiry-tough-questions>
7. The impasse over Rodney's death, where police refused to give evidence at the inquest, led the government to try to legislate for 'closed' procedures at inquests – hearings from which the family would be excluded. INQUEST fought a successful campaign against the provisions for secret evidence at inquests – first proposed in the Counter-Terrorism Bill in 2008, then in the Coroners and Justice Bill the following year, and finally in the Justice and Security Bill, which became law in 2013 and which introduced closed material procedures in all other civil cases, triggered by a certificate from the minister that disclosure of the relevant evidence would be against the interests of national security. But provisions in the 2009 Act allow the inquest to be stopped and for an inquiry to be held instead, at which secret evidence can be heard – and this led to an inquiry rather than an inquest being held into Rodney's death. In 2010, the government announced an inquiry into Azelle Rodney's death, chaired by retired High Court Judge Sir Christopher Holland and with terms of reference similar to an inquest. It heard evidence in public from September to December 2012. Ironically, the inquiry chair ruled that most of the evidence for which the police pleaded secrecy could and should be heard in public. From the conclusion of unlawful killing, and the subsequent murder charge against the officer who fired the fatal shots, concealing wrongdoing, rather than operational requirements, seems to have motivated the demand for secrecy.
8. See <http://dugganinquest.independent.gov.uk/evidence.htm>
9. Home Office Circular 43/2001: Guidance to Police Authorities on financial assistance to police officers in legal proceedings.
10. Police officers involved in recent shootings have had their substantial legal costs paid by the Mayor's Office for Policing and Crime on application by the Metropolitan police. The unsuccessful judicial review launched by 'E7', the officer involved in the death of Azelle Rodney, against the unlawful killing verdict, was funded to the tune of £140,000. This was in addition to the quarter of a million pounds of public funds already granted for legal representation at the inquiry. The officer involved in the death of Mark Duggan has also been awarded at least £156,000 from public funds for legal representation. See the MOPAC decisions on funding on its website: <https://www.london.gov.uk/priorities/policing-crime/mopac-decisions/>
11. The inquest in July 2014 recorded a critical narrative verdict which found that 'Dorothy Groce was shot by police during a planned, forced entry raid at her home, and her subsequent death was contributed to by failures in the planning and implementation of the raid'.
12. Macpherson, op. cit., Recommendation 43.
13. The following year, the Human Rights Act came into force, and public bodies were obliged to give effect to the right to life protected by Article 2. In a case brought by the uncle of Zahid Mubarek (see Chapter 3), the House of Lords held that Article 2 imposed a duty of effective investigation of deaths in custody, in which families must be able to participate, to be legally represented and to question witnesses. (*R (Amin) v Secretary of State for the Home Department* [2003], UKHL 51.) This means that families ought to get legal aid for the inquest if they could not otherwise afford legal representation. Under the Legal Aid and Sentencing of Offenders Act 2012, representation at inquests has been removed from the scope of legal aid, but the families of those dying in custody are eligible under provisions for 'exceptional funding', available when either Article 2 or the 'wider public interest' requires it. Lord Chancellor's Exceptional Funding Guidance (Inquests) (1 June 2014). <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309099/legal-aid-chancellor-inquests.pdf> But legal aid for families is still subject to means and merits tests. Legal Aid Agency, 'Inquests: exceptional cases funding provider pack' (April 2013). <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309095/legal-aid-ecf-inquest-provider-pack.pdf>
14. Frances Webber, 'The ordeal of Kessie Moyo', IRR News (9 July 2009). <http://www.irr.org.uk/news/

the-ordeal-of-kessie-moyo/>

15. Twelve verdicts are available in total. See INQUEST website, 'Section 4.3: Verdicts'. <http://www.inquest.org.uk/help/handbook/section-4-3-verdicts>
16. The chief coroner's first report, covering April to September 2013, recorded 244 PFD reports, of which twenty-four related to deaths in custody, a further ten were mental health-related and four concerned deaths relating to police procedures. They were not broken down by the ethnicity of the deceased. <http://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/coroners/pfds/Summary+Report+of+PFD+Reports+Apr+-+Sep+2013.pdf>
17. It should be noted that the police also carry out an investigation, which can vary from simply verifying the identity of the deceased and informing the family to extensive investigations into the circumstances behind a death. If the death occurs at a privately operated prison, it is usual practice for the company to carry out its own investigation too.
18. *Report on an unannounced inspection of Harmondsworth Immigration Removal Centre, 17–21 July 2006*, HM Chief Inspector of Prisons (2006). <http://www.statewatch.org/news/2006/nov/harmondsworth.pdf>
19. *Report on an unannounced inspection of HMP Wormwood Scrubs, 6-16 May 2014*, HM Inspectorate of Prisons (September 2014). <http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/09/Wormwood-scrubs-Web-2014.pdf>
20. *The Butler Inquiry into Crown Prosecution Service decision-making in relation to deaths in custody and related matters, August 1999* (see below).
21. Macpherson Report, op. cit., Recommendation 58.
22. *Annual report and statement of accounts 2012/13*, Independent Police Complaints Commission. <https://www.ipcc.gov.uk/sites/default/files/Documents/publications/annual_report_IPCC_2013_web.pdf>
23. There is quite a complex division of labour between the IPCC, the police and the local police authorities, some of which have Police and Crime Commissioners (PCCs). Following a death involving police or in police custody, the case must be referred within a day to the IPCC, who must decide whether to carry out a wholly independent investigation; to manage or supervise an investigation carried out by a police force; or to require the local force to investigate the death itself. Where there is considered to be a connection between police contact and the death, it must carry out an independent investigation, using its own investigators. Although it has no powers to discipline police officers, it may determine that there is a case to answer for misconduct or gross misconduct, and recommend disciplinary action, and can direct the appropriate authority to take steps to give effect to its recommendation. Its obligations also include making and monitoring recommendations for improved practice by police forces, and making and disseminating wider lessons arising from its work.
24. A 2008 National Audit Office investigation of the IPCC's work (which did not look at the quality of its investigations, only at its processes) found that 'the IPCC's quality control procedures are underdeveloped and inconsistently applied, and there is no effective external scrutiny of the IPCC's investigative work'. In too many cases, commissioners did not sign off investigations, indicating a failure of responsibility, and the organisation did not do enough to ensure that recommendations on individual cases were acted on and implemented. *The Independent Police Complaints Commission*, National Audit Office, HC 1035 (November 2008). <http://www.nao.org.uk/report/the-independent-police-complaints-commission/>
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6 | Other voices

LAW

The inquest and the family

Ruth Bundey

Starting with her involvement in the Helen Smith inquest, Ruth Bundey has represented families in countless custody deaths of children and adults, frequently without legal aid, over the past thirty years. She was (and is!) solicitor to Janet Alder whose brother Christopher died in a Hull police station, and is currently assisting families of three of those who died at Hillsborough.

ONE OF THE hardest pieces of news to explain to a family who have lost a loved one in prison or police custody is the length of time that will pass before any inquest will take place and, hopefully, answers given to their questions. Numbed by grief and shock, families want as soon as possible to understand the circumstances of the death.

Although the new procedures governing inquests attempt to set minimum and maximum time limits within which an inquest must be held, these at present are unlikely to be met. A death in a police station must be investigated by the Independent Police Complaints Commission (IPCC) and a death in prison by the Prison and Probation Ombudsman's office (PPO) and both these organisations, inundated with cases to investigate, troubled by underfunding and beset by staff shortages, find it impossible to complete their investigations within their own target dates. Investigations range from those that are ineffective or misleading to those which are painstaking and uncompromising, depending very much upon who leads and conducts the investigation. Until the reports are completed and circulated in draft, inviting comments at least as to accuracy from families, police and prisons, the listing of an inquest is unlikely to be contemplated. In some parts of the country coroners have an immense amount of custodial institutions within their geographical catchment area: male prisons, female prisons, young offender institutions, and a multitude of police stations, and for each death that occurs in such a place, whether under state or privatised control, an inquest must be held with a jury. Coroners have set periods each year when juries are summonsed and there is therefore often a long wait for a jury inquest to be slotted in. In the past as much as six years or more could elapse from death to hearing and currently a gap of at least two years would be the norm.

In meeting with a family and reassuring them of the steps to be taken and all the efforts that a family's representative will make to ensure justice is done, the prospect of waiting for such a long period before any sort of conclusion can be reached is a daunting one, which denies the prospect of 'closure' and moving on from the bereavement, since over such a sustained period it would be necessary to discuss and re-discuss the events that led to the death and search for answers.

Simultaneously, for families and their representatives there is the nightmare of the quest for funding. The current policy of the Legal Aid Agency (LAA) appears to be a refusal to consider funding for an inquest into a death in custody until the PPO or IPCC report is available in draft, leaving the family with ongoing anxiety as to whether exceptional funding for the inquest will ultimately be granted, and leaving the families' lawyers with no assurance that any of the initial preparation and investigative work they undertake will be reimbursed unless the next of kin receives minimum state benefits. An additional and tortuous complication is the LAA's insistence upon discovering the financial means of a whole host of other relatives of the deceased, who may indeed be estranged from family members central to the case,

or have no direct interest in the ultimate proceedings, thus understandably resentful at being potentially liable for costs in a case of which they want no part. One can only hope that eventually sense prevails and a system is introduced of non-means tested automatic access to exceptional funding where there has been a death at the hands of the state or its contracted agents.

It is crucial for any family representative to follow up all the points of concern a family raises, and indeed to make sure that the IPCC or PPO is fully aware of those at the outset. Equally, it is necessary to explain long in advance of the inquest hearing, the limitations upon the scope of the jury's determinations, now normally provided in the form of a narrative. The family will be shocked and taken aback if not informed in advance that a jury narrative is restricted to matters which have a causal connection to the death, in other words which contributed in part to the circumstances of the death itself. There may well be evidence of failures to follow mandatory regulations for police or prison staff, which the coroner can take up if not rectified by the time of the inquest, but which of themselves have no specific bearing on the death that occurred.

Nowadays problems of the disclosure of all relevant information to family representatives and/or the coroner's office prior to a hearing are much less likely to occur than in times past, though examples of documents suddenly and surprisingly available, or records that are mislaid or disappear, still occur.

Family members will often be shocked at the number of legal representatives of other parties at the inquest into the death of their loved one, handsomely funded by their organisations or by the State. In a prison death there will be representation through Treasury Solicitors of the Ministry of Justice, representation of the relevant health care providers, possibly augmented by representation of individual prison officers through the Prison Officers Association, and of individual medical staff. An inquest which spans the care (or lack of it) of a hospital patient who is transferred to police custody, or of a police station detainee who subsequently goes to hospital will attract double the number of individual parties or organisations represented, and it is not unusual for a family to find that their lawyer is one of nine or ten others, all with questions to ask and interests to protect. Appearing for a family in such a context can be a lonely experience were it not for the relationship with family members attending which provides such necessary solidarity.

By the time of an inquest hearing, and indeed long before, the wishes of a family are invariably simple and straightforward: that nobody else in their position has to suffer a similar loss of a son, daughter, sister, brother, mother, father or other close relative. Justice for the deceased can only come about if lessons are learnt that can ensure mistakes, once made, do not re-occur.

Sadly, the organisation INQUEST, and those involved as representatives in multitudes of death in custody cases, see repetition of the same kind of failures of duty of care time and time again.

Some families wish to deal and grieve in private with the tragedy of finding that a loved one they had believed had been, if not content, safe in detention, was not safe at all. Other families gain strength and solace from meeting those in a similar position, and to this end the family days and family contacts organised through INQUEST, or through the organisation United Families and Friends, are invaluable. Likewise the number of lawyers heavily involved in inquest work, a relatively small number compared with those in other areas of law, share support, information, and often despair together.

Azelle Rodney: the protracted path to prosecution

Daniel Machover

Daniel Machover is the head of the civil litigation department at Hickman and Rose solicitors and Chair of the Board of INQUEST. He is the solicitor for Susan Alexander, the mother of Azelle Rodney, and also acted for Irene Stanley, the widow of Harry Stanley.

ON 30 JULY 2014 the Crown Prosecution Service (CPS) announced they would prosecute the now retired specialist firearms officer known to the public only as 'E7' for the shooting of 24-year-old Azelle Rodney.

He [has since] made his first appearance at court on 10 September 2014, being granted bail by Mr

Justice Sweeney at the Central Criminal Court.[1] On 3 October the officer was named as Anthony Long and his trial set for June 2015. It will be only the third ever murder trial of a police officer acting in the line of duty. It has been a long and arduous journey for Rodney's family and legal team. At different moments over the past nine years, Rodney's mother, Susan Alexander, has encountered various obstacles, from an inadequate IPCC investigation to difficulties obtaining access to 'secret' evidence that prevented an inquest into Rodney's death. It will be more than ten years on from Rodney's death, that the CPS will attempt to deliver the justice that has been long delayed.

Rodney's death

From mid-afternoon on 30 April, three men including Rodney were covertly trailed by police as a result of intelligence that they were going to rob a Colombian gang in possession of drugs at gunpoint. Orders were given to deploy armed police officers to stop the car in which Rodney was travelling. To do this, unmarked police vehicles used the 'hard-stop' manoeuvre. The Inquiry heard that 0.06 of a second after pulling up alongside the car on a busy road in north London, Long began firing at Rodney, who was sitting in the rear seat. Within the space of two seconds, Long fired eight shots, hitting Rodney six times. The Chairman of the Azelle Rodney Inquiry (ARI) described the fifth and sixth shots as military-style 'double tap' shots fired at Rodney's right ear. A final brace of bullets was fired into Rodney's vertex. It was uncontested medical evidence that with timely treatment Rodney would probably have survived the first four shots, two of which struck him, one in the right arm and one in the back. The ARI report of July 2013 stated, 'Had the shooting ended before or after two shots, Rodney would have lived. Had it ended after the next two shots he would have lived assuming prompt medical attention. With the next two shots he dies, with the last two shots death is confirmed. The less justified the shooting becomes the more lethal it proves to be.' This Inquiry only resulted after years of staunchly contested legal argument, sustained political pressure and rigorous campaigning from Rodney's family.

Initial investigations and the inquest that never was

Following the shooting, the Metropolitan police released a press statement suggesting Rodney was holding a gun when he was shot, leading to misreporting throughout the media. The death was investigated by the newly established IPCC, which confirmed Rodney was not holding a gun when he was shot. The IPCC passed its file on to the CPS at the end of 2005. In July 2006, the CPS concluded there was 'insufficient evidence to disclose a realistic prospect of conviction against any officer for any offence in relation to the fatal shooting'.

Usually, a coroner would arrange an inquest as soon as possible after a CPS decision not to bring criminal charges. However in this case the process reached a standstill as Susan Alexander was denied full pre-inquest disclosure from the IPCC apparently due to restrictions on sensitive evidence imposed by the Regulation of Investigatory Powers Act 2000 (RIPA). Under RIPA, evidence obtained via intercept warrants can only be disclosed to third parties following judicial decisions in criminal proceedings, not during inquests or civil proceedings.[2] Consequently, when coroner Andrew Walker held a pre-inquest hearing in August 2007, he reviewed IPCC bundles of heavily redacted evidence together with 'gist statements' where the original text had been replaced by text agreed to by the IPCC, the police and HM Customs and Excise. This rendered key parts of the evidence meaningless or seriously defective. The coroner decided that the legal restrictions preventing both himself and an inquest jury from hearing relevant evidence precluded him from holding an inquest that met the state's obligations under Article 2 of the European Convention on Human Rights (ECHR).[3]

The Inquiry and secret evidence

The right to life that is enshrined in Article 2 ECHR imposes a procedural duty on the state to implement systems and laws that prevent wrongful deaths from occurring. This also creates an obligation on the state to conduct an effective investigation into any deaths to ensure the accountability of state agents. They must also grant the bereaved family sufficient access to the investigation to protect their interests.[4] In light of these obligations, Susan Alexander threatened to take the government to court to secure a declaration that RIPA was in breach of the Human Rights Act. With the stringent limitations on disclosure imposed by the RIPA conflicting with the state's duties under Article 2, a long and ultimately unsuccessful battle ensued to try to secure legislation that would enable an inquest to be resumed.

Years of parliamentary wrangling followed, with two unsuccessful attempts by the government to introduce 'secret inquests' where specially appointed counsel would have access to evidence that the family and lawyers of the deceased would not. In March 2010, justice secretary Jack Straw announced that a public inquiry would take place instead of an inquest. The Inquiry eventually began hearing evidence on 3 September 2012 after the government delivered Susan Alexander a formal apology at the European Court of Human Rights for the delays in the investigative process, admitting a breach of the 'promptness requirement' of its responsibilities under Article 2 ECHR. Long was granted immunity from

prosecution under RIPA by the Attorney General to give evidence at the Inquiry.

The Inquiry was temporarily halted in October 2012, when the Metropolitan police asked the High Court[5] to overturn a ruling allowing aerial surveillance footage taken of Rodney's movements in the two hours leading up to his death to be disclosed to the family's legal team.[6] The High Court dismissed this claim and the Inquiry proceeded with the benefit of important evidence concerning the 'hard stop' and the shots fired by Long. This included the 'black boxes' from the police cars involved in the hard stop, real-time video and audio footage taken from one of the police vehicles, a reconstruction of the incident and expert evidence on ballistics, pathology, blood splatter and accident investigation.

On 5 July 2013 the chairman of the Inquiry, retired High Court judge Sir Christopher Holland, published his report, which found that there was no lawful justification for Azelle Rodney's death. The report reached the unique conclusion that a police shooting had violated someone's right to life because of the planning of the police operation as well as the conduct of the officer who fired the shots. The chairman was highly critical of police risk and threat assessments. Although he did not expressly state that police had breached Rodney's right to life, this was likely due to the constraints imposed by Section 2 of the Inquiries Act, which stipulates, 'An inquiry panel is not to rule on, and has no power to determine, any person's civil or criminal liability.' The report's findings on Long should be read in full by those with an interest in the case, but with Long facing a charge of murder this is not the time to repeat all those details.

Following the publication of the report, Long applied to judicially review some of the key conclusions of the Inquiry. In February 2014, the High Court rejected Long's judicial review application, highlighting that the chairman had been engaged in the case for three years and no review which the Administrative Court could conduct could match the advantages that he had in that respect.

Finally, a murder prosecution

Long did not appeal the failed judicial review. On 30 July 2014, the CPS announced there was sufficient evidence to prosecute Long for the murder of Azelle Rodney and that it was in the public interest to do so. However the CPS declined to bring charges against the Police Commissioner under the Health and Safety at Work Act, the instrument used to impose liability against the Metropolitan police after Charles De Menezes was mistakenly shot dead by police three months after Rodney's death on 22 July 2005.[7]

Over nine years on from the killing of Azelle Rodney, a number of troubling issues that were highlighted in the aftermath of his death remain unresolved. The problems posed by RIPA remain an obstacle for conducting effective inquests that has not been resolved by parliament. Although an unprecedented public inquiry paved the way for the prosecution of Long, an inquiry is not always an effective substitute for an inquest. Under the Inquiries Act, an inquiry will not involve the next-of-kin the way inquests do, with ministers able to order restrictions on public access to hearings, documents and the final report. The conflict between RIPA and inquests must be resolved to ensure that the protection afforded by Article 2 ECHR is preserved in coronial investigations. Concerns over police planning and strategy also linger. It emerged that the IPCC recommended the hard-stop procedure should be reviewed after their original investigation into Rodney's death.[8] But no such review took place and a 'hard-stop' was used by police when they shot and killed Mark Duggan in 2011. It remains deeply concerning that eight out of the ten men killed by UK Metropolitan police over the past decade were killed during pre-planned operations.[9]

The prosecution of Long will present its own challenges for the state, not least because of the Attorney General's undertaking that no evidence a person has given in the Inquiry will be used against them in related criminal proceedings.[10] Justice has already been delayed for far too long. The CPS must ensure that it is not also ultimately denied by fearlessly presenting the fullest evidence to the jury and showing Long no special favours, so the trial will not only be fair to him but give the public confidence that police officers are not above the law when they shoot someone in the line of duty.

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have sufficient public scrutiny to ensure effective accountability and involve the next of kin to ensure their legitimate interests.

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Holding the guardians to account

Lee Bridges

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IN HER FOREWORD to the Independent Police Complaints Commission's 2014 final report on its work in investigating deaths following contact with the police[1] the IPCC chair, Dame Anne Owers, fully acknowledged that:

> **Deaths during and following police contact have the potential to impact on trust and confidence in the police more broadly. This is particularly true in black and ethnic minority (BME) communities where a number of high profile deaths have caused particular concern. Those who have lost relatives and close friends have little reason to trust either us or the system, particularly in communities where trust is low. We can only earn that trust by engaging with them, and enabling them to participate effectively in the investigation process. Crucially, we need to show that we have been robust in seeking answers to the questions they need answered, that lessons have been learnt to prevent future deaths and, where necessary, that those responsible are held to account.**

The fact that fifteen years earlier the report of the Stephen Lawrence Inquiry (Macpherson Report) expressed very similar concerns about deaths in custody and their impact on BME community trust and confidence in the police and the wider system of police accountability,[2] is indicative of how little progress has been made in the interim.

Accountability – division of responsibility

It remains to be seen how far the changes emerging out of the IPCC's most recent review will ensure that its own investigations into deaths in custody will become more robust and effective, but on the crucial issue of holding those responsible for such deaths to account, the IPCC is itself highly dependent on the actions of other bodies. These are, first, individual police forces which remain responsible for administering discipline against their own officers following an IPCC reference and, secondly, the Crown Prosecution Service (CPS) which is responsible for the decision whether or not to institute and prosecute criminal charges against police officers.[3]

As regards police discipline, the IPCC report, while rejecting suggestions (even from some police forces) that it should take over responsibility for administering police discipline when it has carried out an independent investigation into the matter, is nevertheless highly critical of the current system:

> **We share the frustration where there is a clear disconnect between our investigation findings and the outcome of the misconduct hearing that follows. In some instances, although we have determined that an individual has a case to answer for gross misconduct, the panel at the subsequent misconduct hearing concludes that the individual's conduct amount to misconduct only, or that it amounts to no misconduct at all.**
>
> **In other instances, the panel agrees that the individual's behaviour amounts to gross misconduct but then goes on to impose a sanction that is more lenient than the IPCC and families would expect and which in our view, does not reflect the seriousness of the failings identified.[4]**

The report goes on to call for urgent reform of the police disciplinary process so as 'to introduce independence and transparency into the disciplinary system - as is the case for other professions in the 21st century.'[5]

Unfortunately, the IPCC report is far more circumspect in discussing its relationship with the CPS, stating blandly the current position that 'the IPCC and CPS are independent organisations and each takes independent decisions as part of an investigation into a death.'[6] The report does point to a memorandum of understanding[7] that provides for early notification by the IPCC to the CPS of death in custody cases and subsequent communication between them on the progress of the IPCC investigation, noting that this 'interaction provides an opportunity for us to take advice and guidance on lines of enquiry, the nature of charges and legal and evidential issues in a case before formal submission to the CPS.'[8] Arguably, such interaction during the investigation could be said to compromise the claimed independence of decision-making by each organisation, as the CPS advice may be crucial in determining the IPCC decision whether or not to refer a case for possible criminal charges and the CPS decision on whether to pursue a prosecution may be compromised by advice previously given on the case to the IPCC.

On this latter issue, the IPCC report states that:

> **Once a case is referred to the CPS, the decision on prosecution is solely taken by the CPS ... the CPS are responsible for explaining to the family their decision about whether they will prosecute. We make it clear in press releases that decisions have been taken by the CPS rather than ourselves, and we will continue to emphasise this.** [9]

It is hard not to read into this a policy of distancing the IPCC from the CPS or to escape the implication that the IPCC and CPS find their supposed independence in these matters politically convenient for the purpose of shifting blame when prosecutions over deaths in custody are not pursued or fail. The CPS can claim the evidence provided by the IPCC was insufficient to justify a prosecution or to obtain a conviction, while the IPCC can assert that it is solely a matter for the CPS to determine the standard of evidence required in such cases and how to present it in court.[10] This may well be the underlying reason why the IPCC is less than keen on being given the responsibility not only for investigating but also prosecuting potential criminal charges against the police arising from deaths in custody.

What is to be done about the CPS?

For its part, the CPS has made no acknowledgement of any continuing lack of trust or confidence in its own role in relation to deaths in custody since, following the Stephen Lawrence inquiry report, an independent review was undertaken by Gerald Butler QC at the behest of the then Labour government. The report of this review published in 2003 is notable more for the proposed reforms that it rejected than the changes in CPS practices which it introduced. The latter consisted of widening the pool of CPS lawyers able to take decisions on death in custody cases, so as to avoid the more lengthy delays in the process, and ensuring that decisions not to prosecute were referred to senior Treasury counsel for advice before being finalised.

Yet, the report noted the far more fundamental concern among some sections of the public that 'the relationship between the CPS and the police is too close to ensure a robust approach to prosecuting police' and that while individual CPS lawyers may not be biased, 'the institutions [police and CPS] are so intertwined that their interests are too close.'[11] It is worth commenting here that, if this concern were considered valid, it would also apply to the involvement of senior Treasury counsel in decisions since, although not directly employed by the government, they are instructed on a regular basis to prosecute for the CPS in the most serious criminal cases.

Brief consideration was therefore given to a number of other options for reform, including removing the decision to prosecute in deaths in custody cases entirely from the CPS, appointing a supervising lawyer such as a retired judge to hear appeals against CPS decisions not to prosecute in such cases, or creating a panel of independent lawyers to review such decisions before they are finalised. In fact, the last of these proposals would simply involve widening the group of independent lawyers brought in to review prosecutorial decision-making in death in custody cases beyond Treasury counsel, so as to include, for instance, those with experience of representing families of those killed at inquests or others regularly pursuing cases of misconduct against the police.

The review rejected out of hand the notion that responsibility for prosecutions in deaths in custody cases should be removed entirely from the CPS, in part on the grounds that to 'to establish a wholly new body to deal just with these cases would require a very strong justification indeed' and 'throw up many issues of funding, organisation, staffing and accountability.'[12] However, it is important to note that this was prior to the IPCC coming into existence. In fact, there are a number of bodies that have powers of prosecution separate from the CPS, including notably the Serious Fraud Office (SFO), which combines responsibility for conducting investigations in relation to serious fraud with that for prosecuting such cases. Moreover, the SFO has special powers to compel witnesses to answer questions and to provide documents and other information at risk of prosecution for separate

criminal offences for failing to do so.[13] This precedent may well suggest that giving the IPCC responsibility for prosecuting death in custody cases involving the police and other bodies with 'police-like' powers, along with stronger investigative powers similar to those of the SFO,[14] deserves further and more serious consideration than it has received so far.

Reforming the law

There is also an urgent need, long recognised by many lawyers and campaigners, for a fundamental review of the law on homicide. As the law currently stands, it provides police and others charged in respect of deaths in custody with a number of defences, including that they honestly (even if mistakenly) believed that they or others were under threat from the person killed and that the force used was reasonable, ie, proportionate and necessary to avert the perceived threat. Moreover, in deciding the reasonableness of the force used, the law directs that a person acting for a legitimate purpose (eg, to arrest or detain an offender or suspect) 'may not be able to weigh to a nicety the exact measure of any necessary action' and that 'evidence of a person having only done what the person honestly and instinctively thought was necessary for a legitimate purpose constitutes strong evidence that only reasonable action was taken by that person for that purpose.'[15] This can be contrasted with the law relating to joint enterprise,[16] under which all those involved in an unlawful activity which results in a death can be convicted of homicide, without their having had prior knowledge, intention or belief that such a killing or serious harm to the victim would occur. Convictions under this doctrine can be obtained even if the unlawful act occurs spontaneously and solely on the basis of an individual's presence at the scene of the killing, provided that this is deemed to have given encouragement to another person's actions resulting in the death.

Joint enterprise has over recent years been used as a dragnet device to convict large numbers of young people from BME communities, even while these same communities regard themselves as particularly vulnerable to deaths in custody. In these circumstances it can hardly be surprising that these communities may regard the law on homicide, whatever its technical niceties, as being politically biased against them, allowing their own to be convicted even if only peripherally involved in a killing, while placing substantial legal barriers in the way of holding the police and other criminal justice agents to account for their involvement in deaths in custody.

In some respects, the criminal law continues to treat the police and other criminal justice agents in the same way as ordinary citizens, albeit 'citizens in uniform'. However, this is a fundamental misconception, as the police and other state agents exercising 'police-like' powers are actually sanctioned and equipped to use force (increasingly so) in carrying out functions such as arrest and detention, which in the hands of any other citizens would constitute criminal offences such as assault and kidnap. Given this fact, there is a strong case for the criminal law to place a special liability on those carrying out such policing functions, over and above that applying to other citizens, in cases where these powers are misused, especially if such misuse results in a death. Certainly, until the law of homicide is reformed in this way, it is likely to continue to prove extremely difficult, no matter which agency is given responsibility for prosecutorial decision-making, to obtain convictions against the police and other state agents in death in custody cases.

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2. CM 4262-I, *The Stephen Lawrence Inquiry – Report of an Inquiry by Sir William Macpherson of Cluny* (February 1999). See in particular paragraphs 45.21 and 45.22, pp. 314-315.
3. The IPCC's remit to investigate deaths and refer them for possible prosecution to the CPS also covers those exercising 'police-like powers' (e.g., of arrest) in the employment of other agencies, such as the Home Office's border force. However, it does not appear to cover the work of such agencies in the detention, escort or deportation of persons under their jurisdiction.
4. *Review of the IPCC's work in investigating deaths – Final Report*, op. cit., p.85.
5. Ibid., p. 86.
6. Ibid., p. 84.
7. IPCC and CPS, *Memorandum of Understanding on working arrangements between the Special Crime Division of the Crown Prosecution Service (SCD) and the Independent Police Complaints Commission.* <www.ipcc.gov.uk/Documents/guidelines_reports/MoU_Working_arrangements_between_the_IPCC_and_CPS_Special_Crime_Division.PDF>
8. *Review of the IPCC's work in investigating deaths – Final Report*, op. cit., p. 84.
9. Ibid.
10. A perfect example of this blame shifting is the reasons cited by the CPS for deciding not to prosecute two police officers whose evidence to the IPCC and the inquest into the death in custody of Sean Rigg, that they had checked his condition while he was in a police van on arrival at Brixton police station, was contradicted by CCTV evidence. The CPS declined to prosecute

these officers for perjury and/or perverting the course of justice on the grounds that the IPCC had not itself challenged the officers' accounts, even though the CCTV evidence had been available at the time, and that the officers' recollections given in evidence at the inquest four years later were believed by them to be true since they had not been previously challenged by the IPCC. See 'No charges to be laid against police over Rigg testimony', *Guardian* (8 October 2014).

11. CPS, *A Review of the Role and Practices of the CPS in Cases Arising From a Death in Custody* (July 2003), paragraphs 8.97 and 8.98. <http://www.cps.gov.uk/publications/others/agdeathscust.html>
12. Ibid., paragraph 8.100.
13. Under section 2 of the Criminal Justice Act 1987, answers given or information provided by a person under these powers cannot be used in evidence in a prosecution against that person, unless otherwise available through a separate witness statement.
14. There has been some stregthening of IPCC powers to require the provision of information under the Anti-Social Behaviour, Crime and Policing Act 2014.
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An NGO's account of its history of challenging the state over deaths in custody

Deborah Coles

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INQUEST'S WORK WITH families since 1981,[1] and our monitoring of the inquest and investigation process following deaths in state detention or contact with state agents, has revealed a serious lack of legal and democratic accountability. The experiences of bereaved families are particularly important for understanding the type of state we live in. Their campaigns for truth, justice and accountability in the face of a protracted, complex, intrusive investigation and inquest process and legal, media, and state misinformation and hostility has been critical in placing the issue of custodial deaths and their investigation firmly on the political agenda.

Not all deaths in custody arouse public concern, lead to complaints, generate political heat, or are seen as particularly controversial. It is only when one analyses the patterns of deaths that far wider systemic failings are revealed. The high number of custodial deaths should be treated as controversial because each individual citizen has died whilst in the control and care of the state.

INQUEST has been at the forefront of ensuring that information about exactly how many deaths in custody occur has been made available, analysed and placed in the public domain.[2] Historically these figures were shrouded in secrecy and difficult to obtain.

We know about some of the cases because of their shocking circumstances and the inspiring family led campaigns for justice – but we mustn't forget the hundreds of other deaths that take place behind the closed walls of our institutions. These deaths will never gain public attention but many will raise concerns about the treatment and care of some of society's most vulnerable citizens.

Deaths in custody are not rare or isolated incidents and raise important issues of state power and accountability. The way we treat people in custody is a human rights issue because of the discrimination and degrading treatment meted out to men, women and children; it is a human rights issue because of the right to life and the duty of the state to protect life. When citizens die as a consequence of acts or omissions by state agents it is right and proper that in a democracy such circumstances are subjected to the most rigorous public and judicial scrutiny. This principle is recognised in international human rights laws and by Parliament.

INQUEST's involvement with families, by enabling and facilitating their legal representation at inquests, has been critical in ensuring a more challenging series of questions have been raised about custodial deaths. Our approach of strategically integrating casework, legal and policy work and campaigning has impacted significantly on the legal and political landscape. Historical landmarks include: securing independent investigations of deaths in police and

prison custody with the establishment of the IPCC and the PPO; advance disclosure of investigation reports to families; limited public funding for family legal representation; extending the remit of custody inquests and ensuring more meaningful outcomes in reforms to the investigation and inquest process; ensuring that the Corporate Manslaughter Act applies to deaths in custody and influencing the Coroners and Justice Act 2013; and safeguarding the post of chief coroner.

Exposing unacceptable practices

Properly conducted inquests where families have been represented by legally-aided specialist lawyers and assisted by INQUEST and other NGOs have been crucial in shining a spotlight on the closed world of custody and detention. Many of the deaths have highlighted the abuses of power of institutions/state agents over the powerless indicating cultures of institutional violence, racism, sexism, neglect, and human rights abuses which continue because of inadequate individual and corporate accountability. Cases often reveal a catalogue of failings in the treatment and care of vulnerable people in custody or otherwise dependent on others for their care. They raise questions about the excessive and inappropriate use of custody, and the violence associated with detention which propels individuals to self-harm and suicide. They also highlight failures to fulfil the state's duty to protect life. Inquests repeatedly identify the failure to implement existing guidelines on the care of at-risk detainees. Inquests have exposed the violence of some state agents. Inquests have also exposed the inadequacy of some of the investigations and have dramatically rejected their conclusions.

It is bereaved families, rights lawyers and NGOs who have placed state agencies under public scrutiny, focused on the responsibility and culpability of custodians, and have enabled an alternative narrative and truth to the state official version of events. The struggles and campaigns of bereaved families provide a counterweight to state secrecy and a lack of formal accountability, particularly where people die in closed institutions, and have played a critical role in challenging the inequality, discrimination and unacceptable practices of the state. Without this ongoing, critical oversight, the abuses of power and neglect uncovered at many of these inquests would remain unchallenged and hidden from public view. In turn, this would bolster powerful state and corporate interests, whose interpretation of their role at inquests and unlimited resources is to defend their reputation and policies and practices and limit the remit of the inquiry.

These struggles to hold the state (and, increasingly, private contractors) accountable have exposed fundamental structural flaws in the investigation and accountability processes. Time and time again, state institutions, state servants, and those private firms and their employees to which the state sub-contracts many of its custodial functions, appear to be above the law, and this is in part due to inherent flaws in the apparatus for investigating deaths and subsequent decisions taken post-inquest. These *structural* failings are evident at every stage of state responses to deaths in closed institutions.

First, the investigation stage is characterised by a routine/systematic ineffectiveness on the part of the very bodies tasked with ensuring accountability. INQUEST has been involved with countless cases in which the IPCC has failed bereaved families. In the absence of robust investigations of any death where, for example, the police or prison service are potentially implicated, at best dangerous practices, at worst corruption, go unchecked.

Efforts to prevent scrutiny are evident; state agents conferring before making statements, refusing to answer questions and investigations compromised because of bias, lost evidence, misinformation and institutional reluctance to approach custodial deaths as if potential wrongdoing or misconduct has taken place.

Second, there is the historical reluctance on the part of the CPS to prosecute. And even when they do so, such as in the cases of Ian Tomlinson and Jimmy Mubenga, this was only as a direct result of the evidence uncovered by the family's legally-aided legal representation.

Third, there is an abject failure of the authorities to heed warnings or take action subsequent to previous deaths only to see these same failings or abuses recur in later deaths.

Cycle of violence, neglect and corruption?

The failure to take action confers immunity upon the state and those it employs to keep vulnerable people safe. With immunity comes a culture that at best ignores wrong doing, at its worst condones – such a culture can begin to be pervasive within those who police and detain. To the extent that responses to deaths emphasise that the most powerless and marginalised members of our society can end up dead with little or no consequence, then such actions are not deterred, perhaps encouraged, or at least legitimated and institutionalised.

This cycle of violence and neglect is further fuelled by the ways in which the state dehumanises those it harms, often creating narratives that seek to demonise those who become victims. This presents us with a blame culture that aims to shift attention and pathologises people from black and minority ethnic communities, the poor and disadvantaged, women, children, those experiencing poor mental health, migrants; and a prison population which is already stereotyped. With a rightwing press and media in cahoots, we can see the creation and maintenance of

narratives which aid attempts to obscure and deflect the true role of the state and its agents and its policies and practices. Misinformation or 'spin' has been a prominent feature of many of these deaths with attempts by the authorities to tarnish the reputation of the deceased, 'speaking ill of the dead' in order to build up a negative narrative thereby creating the idea of an 'undeserving' victim. In condemning or vilifying those who die and their families the state seeks to deny the problem by focusing on 'problem' families and communities and the deceased's 'criminal' or 'anti-social' behaviour.

Deaths involving the use of lethal force and violence by state agents have always been by their very nature the most controversial. A significant number of high profile cases have raised public, parliamentary and community disquiet and their impact on police and community relations has been profound resulting in a lack of public confidence in the investigation process and considerable anger about the use of unlawful and excessive force.

Our monitoring has shown discriminatory and deadly policing with a disproportionate number of people from black and minority ethnic communities and those with mental health problems continuing to die in suspicious or controversial circumstances following the use of force. Custodial deaths have revealed a use of violence that is greatly disproportionate to the risks posed, raising questions about racial stereotyping and stereotyping of people with mental health problems.

Demands for accountability

While individual cases often provide the most stark and shocking evidence of systemic and individual failings, a single case is by definition unable to reveal trends or patterns among custody deaths. The integration of evidence-based casework and policy work has been a powerful tool to effect policy and cultural change and has enabled INQUEST to take a thematic view of a number of cases which highlight recurring issues. An example of this type of evidence-based research is provided by our in-depth work on the deaths of children and young people and women's deaths in prison and the disproportionate number of deaths following the use of force on people from BME communities.

It is particularly clear from INQUEST's monitoring and analysis of deaths in custody that understanding why these deaths occur requires an examination of their broader social and political context. Many of the deaths are part of a pattern which impact on policies on drug and alcohol use, homelessness, mental health, crime prevention, institutional racism, penal policy and policing. Deaths in custody cannot be looked at in isolation from issues of poverty and inequality. For example the dramatic rise in the number of prison 'suicides' must be seen in the context of criminal justice policies that imprison vulnerable men, women and children people in impoverished, brutal regimes ill equipped and ill resourced to keep them safe. Deaths in police custody or following contact with the police cannot be looked at in isolation from policing issues generally – particularly issues around stop and search, racist treatment, increased powers under anti-terrorism legislation.

In highly contentious deaths raising issues of possible state or corporate criminality INQUEST's monitoring has shown how the state uses the inquest rather than the criminal prosecution and trial for the public examination of deaths in custody. A number of these high-profile cases have raised concerns about excessive or unlawful use of force or neglect or failures in training and resulted in unlawful killing verdicts and other highly critical jury narrative findings and have led to coroners' reports to prevent future similar deaths. Despite this, no individual has been held responsible either at an individual or at a corporate or senior management level for the institutional and systemic failures – such as improving training or other policies. These cases have also generated significant parliamentary debate and critical comment at a national and international level.

Individual accountability is important and the rule of law needs to apply to all citizens including those in uniform. More broadly, there is the issue of institutional accountability and reflective learning where systemic failures have been identified which looked at collectively reveal broader issues/policies and practices. There is too much endemic complacency to bring about fundamental change. At present there is no proper analysis, auditing and follow-up of inquest findings – in particular whether recommendations made by investigations and inquest have been implemented – there is no mandatory duty to do so.

And so it is left to NGOs, families, campaigners and rights lawyers to deliver scrutiny when the state fails to do so. As a model it is defective on a number of counts. It allows the state to abrogate its responsibility, it creates a fragmented approach when what is required is something more systematic and joined up and it assumes those with an interest in truth, and justice and accountability have the resources to take up the fight.

Successive governments have consistently resisted calls for a public inquiry into custodial deaths. This level of resistance only underlines how important the campaigning and protests of families and civil society are who have joined together with others struggling against state corruption, surveillance, racism and discrimination.

The voluntary sector is looking at increasingly difficult funding times, legal aid cuts are an ideological attempt to limit who can access the

law and on what grounds; and for many of the families we work with, the struggle for justice and accountability takes a terrible toll physically, emotionally and financially.

Another challenge is privatisation. Deaths in all forms of custody are a global human rights issue with the increasing privatisation of prisons and security functions. With this rise we have seen increasing incidences of neglect, ill treatment and a culture of third party denial when it comes to accountability.

The impact of austerity and the cuts to welfare benefits, front line services like mental health provision and youth services, means it is likely more people will enter the criminal justice system because of poverty and inequality.

It is important that we recognise, scrutinise, criticise and argue for reform of the way the state deals with deaths in custody. The closed world of custody means that it is vital that it is open to independent inspection and investigation and held to account when human rights abuses take place. As the Rev. Jesse Jackson said at a meeting with INQUEST and bereaved families: 'Those who have the most power must be the most accountable.'

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References

1. This includes deaths in police custody and following police contact, deaths in prison, immigration and psychiatric detention.
2. See www.inquest.org.uk for statistics on deaths in custody

COMMUNITY

There is no justice, there is just us

Stafford Scott et al

Excerpts from the press launch chaired by community activist Stafford Scott of the Tottenham Defence Campaign in 2011 – a joint endeavour by four black families living within a few miles of each other in North London who had all lost a relative in encounters with the police.

STAFFORD SCOTT: We are a community that, unlike this government, has not lost its collective memory. In this community, if you are over 25, you will know that the people on this platform represent the pain of the black, grassroots community of Tottenham and the wider community of Haringey. Today is the twenty-sixth anniversary of the killing of Cynthia Jarrett. The Jarrett family is here to my left. Also beside me is Myrna Simpson – the mother of Joy Gardner who was also killed in Haringey. To my right are Mrs and Mr Sylvester – the parents of Roger who was also killed in Haringey and beside them is Sean Hall, the brother of Mark Duggan who was also killed in Haringey. Where in England has the media ever been gathered together and asked to look at four families who live in a three-mile radius of each other who have all lost loved ones at the hands of the Metropolitan police service, three of whom, and remember this started twenty-six years ago, have still not received justice?

When we hear politicians, some too young to have read the Scarman report,[1] too young even to have read the Macpherson report, talking about punishing people, removing benefits from a feral underclass, that's not our reality. Our reality is that it erupted twenty-six years ago on the Broadwater Farm estate after a black mother was killed in her home. When we told the world what happened, they told us that sort of thing doesn't happen. When we said a police officer went in there with a key, pushed her over, left her on the ground, while he continued his search. We were told that sort of thing doesn't happen ... We believe in our community that our young people have been imploding for a long time. It has been dismissed as black-on-black violence, so no-one's paid us any mind. When those young people implode it's not much different from when some disenfranchised Muslim brothers decide to turn themselves into suicide bombers and explode. Our young people have been imploding for a long time. Unfortunately they

felt they need to explode and the reason is sitting right on this panel here. The reason? Their experience that there is no justice, there's just us. It's meaningless.

People explode when they have no stake, when they feel they have no alternative. They do it when they believe the power structures, the judiciary, the police and society in general have turned their backs on them. We understand that there were other victims that night. The council, the MP, they make sure that we remember that there were other victims that night [when riots started in August 2011], and let's not forget that buildings, properties and businesses, though they shouldn't need to be, can be replaced. You cannot replace your loved ones ... The impact that I have seen on all of these families has been amazing. It's disgusting that nobody gives them any support and nobody gives them any media space and when 4 August kicks off, people rush around to find reasons, and nobody remembers all these other families ... we don't want to see those scenes that we saw in London, we don't want to see our community burning down. What we do want to see is a country, a people, a society come together, in England in 2011 ...

FLOYD JARRETT: It's twenty-six years since my mother died and we had a public inquiry over which nothing has been done. Nothing has been implemented from the inquiry, which did find in favour of the Jarrett family, whereupon the coroner of the court said it was proven that Miss Jarrett was pushed in her own home, it was proven that the police entered her home illegally with my key, it is not for him to judge intention or unintention it is for a higher court of a higher place. My mother's case has never moved from that coroner's court ...

SS: We are a community that some people describe as hard to reach. But the reality is that we've become easy to ignore. And the only time that they seem able not to ignore us, unfortunately, is when we get into a rage and that's not the community's fault, it's got to be society's fault if that's the only way that people like this, dispossessed people, can have their voices heard ...

RUPERT SYLVESTER: I am the father of Roger Sylvester who died in police custody in January 1999 on the night of the 11th at Whittington Hospital where we were told by three police officers that they went to help him for his own safety and to take him to a safe place. They took him to a safe place alright ... they killed him ... At the inquest, and it take so long to have an inquest, the result was unlawful killing. One officer say at the inquest, just imagine, that Roger was lying on his side, there was at least four or five police officers that was holding him down, one was at his head and shoulders pulling him down and this officer said to the court that Roger lift him up so many inches off the floor. I ask any one of you, try lying down on your side and if somebody held you down on your head and shoulder, see if you can lift someone. [The verdict was overturned in a higher court] ... Ladies and gentlemen, it's a hard struggle, to go through and to see what happened to your loved one. And no answers ... Pain is still there now and we still have the same question ...

SS: Who killed Roger Sylvester? We've had so many killings of people in police stations and police custody yet we've never had an officer charged in any of those killings. Yet last year we saw the wonderful sight of two officers being charged with killing police dogs.

Roger Sylvester was killed in 1999 but they didn't hold his inquest until about 2004, they waited five years, they took five weeks to give the evidence and it took the jury literally five minutes to come back with a finding of unlawful killing. Then when the police put in their appeal, a judge in the High Court then said he believed the jury were confused ... where we have a jury of our peers, we got the result that we sought, when the judiciary got involved they changed the result. But as Mr and Mrs Sylvester say we hold the verdict of unlawful killing to our hearts because we know that is the true and rightful verdict.

Remember that Cynthia Jarrett was not accused of any crime, Roger Sylvester was not actually accused of having committed any crime, Joy Gardner, Myrna's daughter, was accused of being an overstayer and Myrna will now tell you what her punishment was for overstaying in this wonderful, democratic country.

MYRNA SIMPSON: I just want to remind you all of what happened to Joy on that fateful day, 28 July 1993. Joy was at her home in Hornsey, when, I think five police officers and an immigration officer broke in her flat and killed her, by putting thirteen feet of tape around her head and putting shackles on her feet and body-belt around her stomach. And she couldn't breathe and she died. And they took her to hospital and had her on life support machine, she was for five days on the machine ... And when we went up there we saw a lot of police officers around in the hospital and we saw Bernie Grant as well. And we went in and when I went in the ward Joy was at, I saw her wrapped up in foil ... And I touched her and there was no life in her. But they had lots of instruments in her, lots of gadgets were on her and they pretended that she was breathing, but she wasn't breathing. And I stayed in the hospital for five days ... I asked one officer there 'Why didn't you all get her solicitors? Why did you do her bad? She's not a criminal, she's not done any crime. She's a mother of two children. Why did you do that?' I spoke and said I wouldn't like it to happen to no one else but police is killing people and more so black people ... we are not bad people. I've come to this country and I've worked

in this country, myself, my husband, my brothers, my sisters. My father came to this country and we build up this country. We have worked hard to make this country what it is today. We are the ones who have worked and built up this country to what it is so that people can come here and be free in this country.

I am now a pensioner. I came here when my first born was in this country and I've worked hard in this country and I've not got in trouble with the law and I've abided by the law of this country and they've killed my daughter. They have taken my daughter from me, my first child that I had. The most time I had with her was when she came to this country because I left her in Jamaica to go to send back for her, but things didn't work out the way I'd planned it because things were very cheap then. Labour was cheap, we was cheap labourers and we laboured from eight o'clock in the morning until six o'clock in the evening. On Saturday we went to work as well until one o'clock just to make up the money maybe for five or six pounds a week and we had to work and sacrifice ourselves and still there's no justice. But we need justice for our children, our grandchildren and our great-grandchildren.

SS: There are many of you out there who didn't necessarily live through these times with us. You would remember 6 October l985 which was when the riots, the disturbances, the uprisings took place on Broadwater Farm. You never remember the 5th. When you trawl the internet everything's about Blakelock, but everyone's forgotten that a black women was killed, an innocent woman, in her home on 5 October. There have been for the last eighteen months six young men from Tottenham who are on bail for the murder twenty-six years ago of PC Keith Blakelock. For Blakelock we had the most intensive and extensive police investigation in the history of policing – reopened on the day they released Winston Silcott ... We wish they would re-open investigations for us or we would say if you had done your job properly the first time round, if you had gone out and investigated instead of having a witch hunt ... They made him out to be the scapegoat, he was the big, bad man but we proved, we proved ... that in fact he had been framed. What happened to the officers who framed Winston Silcott? They went back to the Old Bailey, the highest court in the land. Only three people know what happened in that room. They were two of them and Winston Silcott was the other one. So what did the state do? The state chose not to call Winston Silcott ... I'm going to hand over now to Sean Hall, brother of Mark Duggan.

SEAN HALL: On 4 August this year I returned from work. It was a normal day. In fact I'd just moved into a new flat and was looking forward to spending the evening there. Unfortunately I got a call from my brother's friend about this dreadful situation. But we were told that Mark was alive and we were about to rush over to Whitechapel Hospital. Why? How did it get so wrongly reported. There's a shoot out – a shoot out between who? To this day we don't know how many bullets were fired. As far as I know I miss my brother. He was a good man. He was no angel, I am no angel but we are normal people ...

What has my brother done so wrong to deserve this death?[2] Please tell me, no criminal record ... as far as we know he wasn't wanted by the police. Why did it happen? Me and my family we thought it was an open and shut case. We were told that this police officer was scared, this police officer wasn't adequately trained to be out there ... who was at fault putting him out there ... We go back to the question, what are the police here for? Are they here to serve and protect us or are they the biggest gang out on the street? Let's find out what happened.

Let's have the IPCC, let's have them get it right. Let's have them prove to this country and internationally that this is a civil rights country and we can come to the right conclusions. (I was looking on a website the other day and I noticed people in Iran campaigning. It brought a smile to my face to see all these Iranian people with cardboard cut-outs of my brother's face in front of them.) The IPCC need to do their job well. We as a family are giving them enough space to do that. I was told the other day that the IPCC want to communicate with us family in writing rather than face to face. Why? I want to see body language and I want to see facial expressions. On a weekly basis we want to be reported to, we want this to be the end to such situations. We want this to be a turning point in this sort of situation. We want this to be a judicial precedent. I don't believe my brother died in vain. I was told the other day that my 10-year-old nephew was leaving the house and he was asked was he in the same gang as his dad – a boy who has already lost his father, who is in turmoil ...

I don't think any one of us wants to be on this stage here telling our stories but we are doing it for a reason ... we will get through this together but, as I say, we want justice.

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1. Lord Scarman was appointed by the government to enquire into and report on the 1981 Brixton 'riots'.
2. Note that this was said in 2011 and far more details emerged during the inquest in 2014.

Pace yourself, it's a long hard slog!

Janet Alder

Excerpted from Climbing over state mountains, *a memoir about campaigning for justice for her brother Christopher, being written by Janet Alder.*

IT WAS JUST three months after Christopher's death [on the floor of a Hull police station custody suite in April 1998] that the campaigning really started. I met up with people in Burnley and Hull and no-one seemed surprised I was having difficulty getting answers; everyone I spoke to said they would lend support in any way and intended to make others aware. I began to visit many towns and cities around the country. Losing my job left me with time on my hands and I took the opportunity to let people know my side of the story. I felt inspired by the other campaigners for justice and their courage to stand for truth, justice and ordinary people – taking a stand for what they believed.

Ruth [Bundey] didn't seem to mind me campaigning and speaking to people. Ruth's experiences of dealing with families that had lost loved family members in police custody had made her well aware. It was not abnormal for families to become fractured with different points of view, some wanting to bury their heads and make everything disappear and others feeling the need to find out what happened, to enable them to make sense of things and move on. Well, I was one of the second kind, my grief and suffering caused me to want to know. Ruth is a brilliant woman and a rare type of solicitor. She always treated me with respect and was understanding of my frustrations after I had read the documents she sent me. I couldn't understand why Christopher wasn't alive and really needed to understand!

On 19 August 1998, I spoke at a meeting for the first time at Blackburn library. This is where I met Sukhdev Reel for the first time. She is the mother of Ricky Reel. Her story shocked and scared me - her son, a young Asian boy, had been found dead in the River Thames. It was believed he had been chased by a gang of white youths and no one had ever been held accountable. His mother found the strength, through her grief, to campaign and travel all around the country to small and large meetings making people aware. All I could think was how this could have easily happened to my own children. Listening to her speaking was distressing; her son must have been terrified. While on my campaigning trail I also met up with Michael Menson's family [Michael was murdered in 1997 by being set alight]. I became close to his brother Kwesi for his family had been campaigning for years and he gave me words of advice, 'Pace yourself, it's a long hard slog'. These were just two of the many campaigns I had made contact with. It began to gnaw at me seeing the number of ordinary families destroyed and affected by injustice but, at the same time, by meeting them I was also inspired to carry on fighting.

I began to see that it could happen to anyone totally innocent. Finding people willing to support you is vital especially when it seems the authorities want to ignore you, pick you off, side-line you, ignore, dismiss, intimidate you and worse. It seems to be that working-class people's voices are drowned out.

Andy [a Justice for Christopher Alder Campaign supporter] arranged for me to go to Blackpool to lobby the Labour Party conference and drum up support from the many people marching. I had never been anywhere near a politician and I wasn't particularly politically minded. The last thing I expected was Christopher's death to be any way political. As we arrived, I'd never seen so many people congregating together, there were all sorts with big banners: Socialist Worker, trade unions like Unison, Natfhe, PCS, RMT, NUT, ASLEF, GMB, NUS, thousands of people from all regions of Britain. They were standing up fighting to stop students being charged fees for their education and there were people fighting for pensions, there were those, with great foresight, fighting to stop the privatisation of the NHS - this was in 1998. I was mesmerised and at the same time still very confused. We stopped the coach outside a hotel, and, as we did, Andy and a couple of others got off and started running towards a big black car. I heard Andy say 'Mo Mowlam we want to know what happened to Christopher Alder', he was flashing the banner he was holding with a picture of Chris in her face. My eyes widened and I thought, God what is he doing? This woman, small, rather round, with hair thin on top was hustling to get in her car and escape the barrage of people, off she went and was gone.

It didn't take me very long to realise that Andy was right, we did want to know what happened to Christopher. I spoke to over a thousand people and they were prepared to listen to what I was saying. It didn't take a lot to convince them something was wrong, they seemed to understand. Slowly, I felt my thought process changing, I was watching the news

more and taking more notice of things going on in the world, things were hitting me. I was hurting inside but the crying ended. I had to stop fighting for the simple life that I had known, going around with my eyes closed and accept my life as it now was. I had made a decision on the first day I went to the police station, I would accept the trials and tribulations. The continual delay and obstruction felt like walls put up by the authorities - part of their defence strategy, undertaken in the hope that I would tire and give in, hoping I would get worn down and fall by the wayside or die of the pain I felt.

In October 1998, the first donations from trade unions came in for the campaign. This made it easier for me to get to other meetings and join in unity with other campaigns and to also make people aware I was in need of their support. The campaigners in Hull did a massive local leafleting job making people aware of where the campaign had got to and the direction we were going in – all covered in the local press.

In 1997, the then home secretary, Jack Straw, had appointed Sir William Macpherson to chair the inquiry into the death of Stephen Lawrence. This is when I first met up with Neville Lawrence after seeing him and Doreen time and time again on the television. Stephen's parents fought a tenacious campaign. They woke up a racist system and made it look at itself, even though they were denied the justice they were entitled to. The inspiration they have given to me and many other families fighting is immense. They showed us that as black people we didn't have to sit and endure the disregard for our loved ones' lives. Neville's words 'Keep fighting!' stick with me now. I felt encouraged by his words. It took his family until 2012, when two men, Dobson and Norris, were found guilty of the racist murder. The family successfully brought the perpetrators to justice – this is inspiring.

The last Saturday in October, each year, the United Family and Friends Campaign (UFFC) holds a silent march from Trafalgar Square to Downing Street. Here I was to discover just how many other families around the country were in a similar position. The procession brings people of all races that accuse the state of killing their loved ones. They speak of their family members dying in controversial circumstances with no justice. It has shocked me over the years to see more and more new families attending the annual UFFC march.

In 1998 (and religiously every year after) I travelled to London and met up with other families, from all over Britain, with loved ones lost in police, prison and psychiatric custody. Children, mothers, fathers, brothers, sisters, aunties, uncles, nieces, nephews, full families as well as friends. Gathering at Trafalgar Square with placards, calling for the cover-ups to be stopped, wearing T-shirts boldly printed with the names and faces of those we are not prepared to let the system forget, loved ones are brought back to life by families whose lives have been torn apart by the denials of those employed to maintain law and order, all marching, demanding truth and justice. I remember from that first march there were strained and distorted frowns of grief and tears from everyone on the march feeling a common loss. We were surrounded by an intense fiery energy of defiance, shouting so our voices could be heard, not just by the prime minister but by passers-by and visitors to London who sat on open-topped buses. Chants of 'What do we want? JUSTICE!'; 'NO JUSTICE, NO PEACE' echoed down Whitehall.

That day in 1998 I remember Brenda Weinberg, the sister of boxing promoter Brian Douglas who died five days after struck by a baton during his arrest in 1995, criticised the police for their treatment of victims' families. She said that the whole process was one of 'damage control'. She said families felt alienated by the process, the door was very much closed to them. Brenda criticised the persistent failures of the CPS and the PCA, aided by the police, to bring any charges against officers responsible for causing deaths in custody. 'We find ourselves in a situation of fighting for information about our loved ones', she said, 'If we become emotional that is used as a derogatory characteristic of black people.' Accusing the PCA of bias in its investigations, she asked, 'How can the PCA expect the public to believe the police can investigate the police?'

Then there was Myrna Simpson, a little old black lady, with a fantastic smile, chubby cheeks and she had probably campaigned longer than a lot of us. Her daughter, Joy Gardner, was arrested by the immigration and police officers and was going to be deported. She is getting on a bit is Myrna, but she still fights for what she believes. She should really be able to retire with some relaxation time, but this will never be for her, as justice has not been served.

The list goes on. The same identical patterns emerging, the same words were being said in 1998 as they are still today. How is it that some people are somehow just falling dead in police custody through alcohol or mental illness? The system is made worse by those who fear to use the words 'police brutality', like somehow they believe that if they were to use those words that the public would lose confidence in the police, when the biggest erosion of civil liberties is the failure to address the police's abuse of power.

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MEDIA

The road to Injustice

Ken Fero

Ken Fero is a founder member of the radical documentary group Migrant Media and examines its role in the formation of the United Families & Friends Campaign and the film on deaths in custody which shook the establishment. A longer article, from which this is excerpted, will appear in Race & Class.

MIGRANT MEDIA WAS instigated by a group of people who were both activists in their own communities as well as artists, filmmakers and writers. We had a foot in both camps and therefore a political direction to our creative outputs ... We had come from a lived experience of colonialism and/or imperialism so it was easy to see the links between workers' exploitation and imperialist violence. Our intention was to make media that spoke for our communities, that gave them a real voice, because there was a lot of victimology around at the time ... Within our community organisations, part of our role was to help to set up interviews with workers for television and we were always angered by the portrayal of our people, so we decided not to be such 'guides' anymore. Ever since then, our focus has always been about people who fight oppression. Migrant Media tells narratives of resistance.

We rented a small studio space in a cultural venue in Hackney and started working out of there. We got the funding week by week from different small projects, from the council, local authorities and then eventually places like UNESCO, the British Film Institute and the European Commission. In these projects we would train Turkish women or Iraqi youth or refugees from Iran - specifically for those communities. We would run events and conferences ... Even though we weren't making films for lack of funding, we would hold screenings with filmmakers we respected and then discuss the content and how we could work together ... Through attending the Black & Third World Radical Bookfair we were in contact with a film activist group in France called Agence Im'Média, led by Mogniss Abdallah. We sat down with Agence Im'Média and in 1990 we agreed that we would make a series of films called *Europe: Communities of Resistance*. The first, made in Berlin, looked at the racist murders of Ufuk Sahin, in West Germany and of an Angolan worker, Antonio Amadeu, in the East, and also included the case of a Turkish youth, Ayhan Ozturk, who killed a German in self-defence. The film featured interviews with the families concerned and reconstructed each case with eyewitness accounts. We met the grassroots activists in the black and migrant communities and examined the increasing racism in the 'new' Germany (the Berlin Wall 'fell' while we were there). The film was called *Germany: The Other Story* (30 minutes/1990).

We had made our first documentary, so we tried the UK broadcasters for support. Quite a lot of Arabs were involved in Migrant Media initially and that was the focus of the first film that we suggested to the BBC. They accepted the idea and it was called *After the Storm* (30 minutes/1992), about the working-class Arab community in Britain ... It was ready to be screened and an exciting time. We then got a call from the BBC saying that there was a problem with the film. Something that was in the film was inaccurate ... It could incite a lot of reaction because it was too confrontational. In particular, there was one section in the film where Dr Ghada Karmi, who we'd interviewed as a Palestinian activist, had said that 200,000 Iraqis were killed on the road from Kuwait to Basra when the US carpet-bombed it. The BBC claimed that figure was inaccurate. What they didn't know was that after the interview with Ghada we had got the figure verified and the Pentagon was the source. The BBC told us after that film went out, because we had refused to compromise, we would never ever work for them again. So that is what has happened.

Britain's Black Legacy (45 minutes/1991) was produced just before *After the Storm*. It covered a thirty-year history of resistance to racist attacks in Britain; again that was a co-production with *Agence Im'Média*. We were filming interviews with Darcus Howe, Linton Kwesi Johnson, Suresh Grover, Frank Crichlow and others and looking at how black communities had organised over a long period of time. The film ended with the death of Rolan Adams (so it was before the death of Stephen Lawrence).

As we had now made a film for the BBC and had 'broadcast credibility', Channel 4 commissioned us to make *Sweet France* (52 minutes/1992) about the history of the Beur movement in France, especially how they organised against state oppression ... That

went out on Channel 4 *sans problème*. What we found was that different broadcasters reacted according to national interest. So the Germans were happy to show *Britain's Black Legacy* but it's never been shown in Britain on television.

During that period, Migrant Media itself was evolving. We were getting bigger and by this time it was around twenty people and quite a few of us were asylum seekers, so we decided to do something about the issue. We went back to Channel 4 and were commissioned to make *Tasting Freedom* (50 minutes/1994). We had links with the Algerian Community Centre in North London and also with the Zaireans in COREZAG in East London, at that time Mobutu was in power in Zaire and the FIS on the attack in Algeria and these were the two largest nationalities being detained in border controls. With other activists we formed the Campaign Against Immigration Act Detentions (CAIAD). That activism developed while we were doing *Tasting Freedom* with the campaign set up in conjunction with the film. The other films were radical in their outlook and were a documentation of what was going on. This was more proactive. It involved a detainees' hunger-strike for which we acted as press office. There were also escapes happening ... At the same time as that was being made Joy Gardner was killed during a forcible deportation.

We got commissioned by Channel 4 to make *Justice Denied* (50 minutes/1995) which they called *Justice for Joy* - even the title was a battle! ... The film wasn't about the individual story, it was wider, about what was happening to the community to a certain degree in terms of deportation. So we decided to cover the deaths of Kwanele Siziba and Joseph Nnalue, who both died during immigration raids, which were fearful events for many people, especially after Joy's death.

The film was commissioned by Channel 4 ... We had to negotiate and agree every word and image in the film. It got to the point where Channel 4 wanted us to remove any images in a demonstration where you would have a placard saying Joy was killed. They wanted us to rewrite history but also play down the anger, but we argued that the footage was of the time so it was representative of the campaign and the feelings on the street. We won every argument, because we had evidence to back it up. On the street, Joy's family had been helped by the Tottenham MP, Bernie Grant and many others. They had waged an effective campaign and we made the film from the family's point of view; we were also part of the campaign.

The film was broadcast on a Monday evening in a primetime slot. The telephones at Channel 4 just didn't stop ringing - mostly with complaints about the film being anti-British, that immigrants deserved to die and threats to ourselves. It was a torrent of abuse and hatred, by and large, but with some very positive reactions also. Joy had been demonised since her death by the press, so we were not shocked at the negative public reaction. In the minds of the public, Joy Gardner was a mad, violent, black woman because that is the image that dominated the narrative in the mainstream press. When we came up with a different point of view, based on truth, obviously people overreacted in a massive way.

We were more surprised though, that Channel 4 then claimed that they didn't actually want to make the film in the first place! They did not defend the film ... the Channel effectively said 'you can't make a film for us again unless it is something about Arab design or Caribbean cooking'. They wanted soft, ethnic 'lifestyle' programmes.

Unlike television, we were never looking to just make films and then walk away from the people involved; it was our community. There were links between all the issues we had focused on – policing, deportation, refugees, migrants, war - and for us it was driven by our political point of view which was one based on race and class but in the framework of resistance. We obviously had been aware of deaths in police custody but, just like most other people in the country, we hadn't actually gone into it in that much detail ... The more we looked into it, and obviously the book *Deadly Silence* by the Institute of Race Relations was a real eye opener, we just thought well there is something here.

At the same time, when we were investigating, we decided 'Well they wanted us to dumb down so instead what's the most controversial thing we can do?' We did the opposite of what we were told to do. 'The police are killing people, let's see, let's look into it' we thought ... No journalist had actually listed the numbers of deaths, which for us was a very basic journalistic exercise and the fact that nobody had counted we thought 'there's something going on here'. Well we got a phone call that there was a protest at Stoke Newington police station for Shiji Lapite and we went down there and that's how *Injustice* started. That's how the film begins and basically we just decided to follow the cases that were most active in terms of family campaigns, which were Shiji Lapite, Brian Douglas, Ibrahima Sey and later Roger Sylvester.

Whilst the families were being supported really well by some campaign groups, we felt that the individual families needed something a bit broader which gave them more control because there was a kind of repeat cycle going on and something needed to shift. There were lots of outside groups involved but the fact that the families weren't meeting each other was, we thought, a mistake. We thought let's see if we can get these families together, and it was myself and Minkah Adofo we got together with

Brenda Weinberg, Brian Douglas's sister and Myrna Simpson the mother of Joy Gardner and formed the United Families and Friends Campaign (UFFC). We soon organised a meeting with the other families, without the campaigners, and then it really took off.

It worked for lots of reasons: because there was empathy between the families, because they were at different legal stages, and they could support each other. There was an emotional connection and it wasn't just politicising. We met with the families once every two weeks for about four to five years. That's a lot of humanity, a lot of communication and that made all the difference. Initially the outside campaign groups weren't really interested, but when they saw all the families coming together that's when they had to support it. That's when UFFC really grew, and it became the coalition of the family campaigns because the families wanted it to happen so everyone else, the 'activists', had to either go or stay. What the families wanted was radical and direct - simply the prosecutions of police officers for murder or manslaughter.

In terms of the issue of deaths in custody, the other side obviously is that it's mostly women who are left organising, as most of the deaths are primarily of men. And there is a strong emotional force there and that had struck hard in terms of the state because it couldn't really 'handle' the impact of the grief that poured out of the families. They couldn't say that these were just grieving women because there was so much political articulation through what they were saying. If it had just been the political activists in front they would have just been dismissed, but you can't dismiss grieving parents. Overall there was more of a willingness to listen to the voices of the families. That's how UFFC started and continued while we made the film, which was over a seven-year period.

Injustice was unfunded initially. We had cameras so we were filming campaigns as we went along. We had no idea what we were doing in terms of a structure to the documentary so that's why it starts in 1993 and ends in 1999 ... Eventually we had funding from the Churches Commission for Racial Justice which gave a little bit of money as did London Film & Video Development Agency and then a few smaller donations, but the majority of the money came from the Soros Documentary Fund, which gave half of the total budget for the film which was £40,000. Seven years' work and a high quality film produced on a budget that would not even make a cheap television half-hour! ...

The impact of the release of *Injustice* was incredible. At the time, families had been complaining about the ineffectiveness of the Police Complaints Authority (PCA) that was responsible for overseeing the police investigating deaths in their own custody. People like Stephanie Lightfoot-Bennett, whose twin brother had died in police custody in Manchester, had already taken it to task in a very public way, but getting the families together in the way we did was important. It was that powerful emotional force, with a clear political strategy and very clear demands that had the impact. The families wanted the PCA abolished. Peter Douglas – the brother of Brian – made the statement clearly in the film. *Injustice* was a deathblow to the PCA.

When it was released, that was another story itself in terms of the state reaction.[1] From our point of view, we couldn't spend seven years making a film and just show it and move on. We then spent many years taking the film round ... It has made a difference in terms of awareness and certainly now there is a recorded visual history, a collective memory for people to refer to. There was also a massive public response - from revolutionaries through to judges - to support us when the police attempted to get the film banned.[2] And this shook the establishment on the issue of deaths in custody.

In terms of the actual cases there had still never been a successful prosecution and that was something we wanted to challenge. We decided to change the terms of debate by calling 'deaths in custody' human rights abuses ... It came through our knowledge of Malcolm X and the work he did in the 1960s ... In the end, the Crown Prosecution Service (CPS) was forced to prosecute more cases after the review of its decision-making process which the Attorney General, Lord Goldsmith, revealed at one of the high-profile screenings of the film. The review came out in 2003 and two cases in that year led to prosecutions of the police for manslaughter and negligence. It felt as though the tide was turning, for at the same time we saw the replacement of the PCA by the Independent Police Complaints Commission (IPPC). We were involved in all those meetings with the IPCC and the CPS so we thought it had an impact, and it had, at that stage. A few years later it started to go wrong, with the CPS and IPCC backtracking.

It's over twenty years since the release of *Tasting Freedom* and *Justice Denied* and obviously the struggle continues. We are just on the outside, sometimes we are involved, and sometimes it's personal, but there is always a struggle going on. How it's documented, how it's articulated and how people who are creative can be part of that, more than just using it as a 'subject', needs to be dealt with ... That people organise, form an 'organic' development, between let's say intellectuals or activists or creative people on the one hand and people in the struggle on the other, is a model that works and works really well - but it's framed in life-spans.

I think what we did with Migrant Media and UFFC are actually quite useful models that could still work despite the changes now in terms of fractious politics, people's attention span influenced by social

media and all that kind of thing. We spent years taking *Injustice* round and challenging people. It's still banned in Britain, but it's been broadcast across the Middle East, Africa, America and in Europe as well as New Zealand and many other countries. It's been reported on CNN. This means that it's a victory in terms of the battle for people's minds around the image of the British police and what happens in Britain. The film is out there. Millions and millions of people now know about Brian Douglas and other deaths in custody. That's another victory in a sense in the battle for justice.

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The defamation of Joy Gardner: press, police and black deaths in custody

Ryan Erfani-Ghettani

Ryan Erfani-Ghettani writes on the media for the IRR. A fuller version of this article appeared in Race & Class *(Vol 56, no.3 January 2015).*

WHEN A DEATH in custody takes place, the majority of the UK's media outlets close ranks with the authorities. A significant section of the popular press – the *Sun*, *Daily Mail*, *Daily Express*, *Daily Star*, *Sunday Times*, *Telegraph*, *Spectator*, London's *Evening Standard* and the now-defunct *News of the World* – appears to go on what can only be described as an ideological offensive the minute that a controversial death in police custody comes to light.[1] Victims' families are left not just fighting to find out how a loved one died, but also to restore his or her reputation. The police force, supposedly keen on policing by consent and accountable, immediately and as of nature closes ranks after a controversial death. Then, more often than not, information about operations only reaches the public via a carefully calibrated statement from the PR department. The Metropolitan police's budget for its Department for Media and Communications speaks of the significance it puts on managing its media profile: on average £7.2 million per annum between 2009/10 and 2012/13, jumping to £9.5 million in 2013/14 when its communications were centralised.[2]

It is reasonable to expect the media would want to investigate injustices perpetrated by the police, especially those involving a number of witnesses. But this is rare.[3] What's more, an influential section of the press takes the side of the police and, invariably, ends up blaming the victim. This is not necessarily to suggest conspiracy; the print media has become over-reliant for copy on the output of PR departments, which are vulnerable to manipulation by vested interests. Coupled with a tendency to select 'safe facts', ie, 'those which can be attributed to official sources',[4] it is easy to account for the near-consensus demonisation of victims of police violence and the marginalisation of their families' attempts to mount a defence.

Typically, the rightwing press goes on the offensive at key moments in the progress of a death in custody case. Immediately after a death, the press may pin the blame on the victims: they are 'illegal' immigrants; they have exceptional strength and so make necessary the use of force; they are armed and dangerous 'gangsters'; or they are drug abusers and therefore erratic or unstable. After public outcry, the press line changes: community protesters are politically motivated, and have been made to 'play the race card' by an anti-racist lobby that sees racism where it doesn't exist. When charges are brought against officers, the press either casts them as 'bad apples' (which exonerates the wider structures of policing from blame) or the victims of a pervasive 'political correctness' that has corrupted Britain's judiciary. During the inquest into the death (or on the rare occasion that officers face criminal proceedings), the character of the deceased rather than the police is again in the media's dock. And, after the trial is

over, the press may give the officers involved the opportunity to tell their side of the story, and honour them for their high-risk, but necessary, work.

'The dead can't answer back'

The case of Joy Gardner showed the lengths to which the rightwing press will go to exonerate the police and blame a victim for his or her own death. Gardner died on 1 August 1993, after deportation police took her by surprise and raided her home, 'trussed her up' in shackles and body belt, and wrapped thirteen feet of sticky tape around her mouth. After she died, the Met's decision to 'manage' the media's response was clear. Two days later, Met Commissioner Paul Condon addressed a press conference to announce an investigation and the suspension of the officers involved, which they themselves later described as a 'theatrical gesture'.[5]

The anonymous authorities testify

In the following days, sections of the press used 'anonymous' police sources to imply that the officers were the real victims: an anonymous colleague of Commissioner Condon was referenced in a *Sunday Times* story claiming Gardner had 'grabbed a shard of broken china and raised her hand as if to stab' the officers; a 'go between' for the officers claimed in the *Evening Standard* that they had been briefed that Joy was a 'strong and violent woman'; unnamed police sources claimed in the *Telegraph* that '[a]mong the things she threw at the police were a telephone, crockery and glass jars'; other police sources justified the use of restraint based on the officers' potential fear that Gardner 'might be HIV-positive'.[6] Meanwhile, Tory MP Teresa Gorman announced that Gardner was 'bumming off social security'; she was thanked for her reminder of the 'sad truth' by the *Daily Express*.[7] The *Daily Star* went further and implied that Joy Gardner had brought her death on herself. 'Why the hell was she here anyway?' it asked. She was 'an illegal immigrant, and therefore criminal ... a violent uncompromising woman'.[8] To back up its claims, a passport photograph showing an unsmiling Gardner accompanied reports. It was an effective mugshot.

The day after the Met's press conference, details of an affidavit sworn by Gardner's husband were uncritically reproduced in newspapers (raising the question of how such evidence was so swiftly available to the UK's media). This testimony had served as the immigration squad's brief. It claimed that Joy had been violent towards her husband, had even tried to kill him, and that her violence had turned her own family against her. This was later supported by an unnamed Home Office official with 'detailed knowledge' of Joy's case, who told the *Sunday Times* that Joy was 'a very bad woman'.[9] Joseph Gardner, a 'partly disabled' man, had been forced to go to court to obtain injunctions against his own wife just five days after their 'marriage of convenience': 'he claimed he feared for his life and said he had been beaten'. 'How I came to live in fear of her', read the *Daily Mail*'s headline.[10] By the next day, reporters had tracked down Mr Gardner and door-stepped him. 'It's true she hit me', he reportedly claimed, 'but I don't want to go into details unless you pay me a lot of money. Then I'll tell everything.'[11] His claims were rejected by Joy's family and friends. 'Lies are being spread about my friend Joy', said Nellie Sterling. 'The dead can't answer back'.[12]

A few bad apples

The press did scrutinise the restraint belts and gagging methods that were often used during deportations, which were 'barbaric', 'mediaeval devices'.[13] But the media's focus on their use allowed officers in the deportation unit to say that they 'went by the book';[14] if these devices were deadly, those who commissioned them were to blame, and that decision came from higher in the chain of command. Newly-appointed Commissioner Condon was now potentially in the dock. Yet a flattering *Sunday Times* feature rescued his reputation.[15] Condon was the 'brightest officer to take on Britain's top police post', and was 'passionate about what he calls "ethical policing", the touchstone of his new doctrine at the Yard'.[16] It was only Condon's 'characteristic speed and decisiveness' that stopped Tottenham's black community from rioting, after he recruited the trusted MP Bernie Grant to call for calm. Furthermore, it was claimed that the discredited deportation devices had never been authorised, and had been developed by the Met's immigration unit 'for their own purposes ... in house'. These allegations, which pinned the blame on rogue officers, were not investigated by the feature's author.

It should be noted that not all sections of the press took the *Sunday Times*' lead on the issue of rogue officers. The article sparked a backlash from the suspended officers, who, through an 'intermediary', were given voice in the *Evening Standard* to recount in forensic detail their version of the day's events. The officers took pains to show that they had gone beyond the necessary safety checks, had taken proportionate measures in the face of extreme violence, and claimed they were being 'made scapegoats' by the Met's handling of the case. In the following days the story was picked up by most tabloid newspapers,[17] all of which framed the officers' actions as a by-the-book response to a 'berserk' woman.[18] The line was that although the officers' guidelines on dealing with deportees allowed for too much force, Gardner's violence gave officers the right to use every measure available to them. In many papers, these features overshadowed the news, officially released on the

same day, that an independent post mortem had found that Gardner had 'been suffocated'.[19]

Preventing public disorder or discrediting community anger?

After Gardner died, demonstrators took to the streets. Her death reminded Tottenham's black community of the death of Cynthia Jarrett after police raided her home in 1985. But the press reminded its readers of the subsequent Broadwater Farm 'riot' that erupted in its aftermath. The focus shifted from an act of police violence to the potential public order threat now posed by the community's protest. Those who came to support Gardner's family and back their call for justice were painted in the press as the source of the violence. The *Sun*'s Richard Littlejohn implied that there was no authentic community anger surrounding her death, before declaring that those protesting 'wanted a riot' and should be dealt a 'healthy dose of police brutality'.[20] The same day, Littlejohn berated Tottenham MP Bernie Grant on London's LBC radio, insisting that Joy 'was not killed' by police, and repeatedly asking him 'Did you want a riot?'[21] This angle was not the sole domain of the rightwing press; it quickly spread to those in the press who had previously been sympathetic to Tottenham's black community, who had endured 'colonial-style' policing. [22] A campaigner speaking on a platform shared with Joy's mother Myrna Simpson, was accused by the *Observer* of preaching a 'gospel of violence' and charged with trying to 'fan the flames of inter-communal hatred' among a packed meeting of Tottenham's black community.[23]

The media's interest in the case waned until the decision on 27 April 1994 to charge three of the officers involved in Gardner's death with manslaughter. The police went on the attack, with the news media providing them a platform. Police representatives labelled it a 'political prosecution', an act of 'scapegoating', 'taken to appease anti-racism campaigners'. It was, according to the Police Federation, a 'sad day for British justice'. It set about providing the evidence for police claims that the Director of Public Prosecutions, Barbara Mills, had been forced to act by an opportunist anti-racist Left. 'The circumstances of Joy Gardner's death were tailor-made for the rent-a-mob Left', said the *Daily Mail*. 'As she lay on her deathbed', it claimed, 'the Left was ready to roar'.[24] Meanwhile, it published an exposé of Mills, condemning her record and taking its cue from the Police Federation, which claimed she had turned the CPS into a 'Criminal Protection Society'.

The attack on anti-racism was renewed in the trial's aftermath. Richard Littlejohn, now writing for the *Mail*, accused Tottenham MP Bernie Grant of having 'blood on his hands'; it was Grant, argued Littlejohn, who had advised Gardner to resist deportation, and this resistance led to her death, out of which he had made 'political capital' by protesting against police violence.[25] *The Sun*'s Leo McKinstry also attacked Grant for 'banging on about racism'. He went on to attack the government's anti-discrimination body, the Commission for Racial Equality, which, he implied, was guilty of having 'stir[red] up race hate', overstating the extent of racial discrimination in the UK in order to justify its staff's 'bloated' taxpayer-funded salaries.[26] Anti-racism was the real cause of grievance among black people!

Character assassination

During the trial, the Met's legal team tried to disprove that the restraint techniques had anything to do with the death at all. They claimed that it was not Met officers' use of sticky tape wrapped around her airways that had caused her to die, but a fall and bang to the head, suffered because Gardner was among the most violent suspects they had encountered. This line, of course, corroborated press narratives that associated black people with violent crime.[27] The headlines blared: 'The most violent woman I have ever met' (*Today*), 'Raging Joy Gardner sank her teeth into me' (*Daily Mail*).[28] The defence brought out her ex-husband, who claimed Gardner had tried to kill him (he had found the gas stove turned on in the night), and said he 'had to lock valued possessions away for fear they might be stolen'.[29] By the end of the trial, the job had been done. According to the *Spectator*, Joy Gardner had, 'in effect, killed herself'.[30]

Reverse racism and the rehabilitation of the Met

The officers were found not guilty, but were now personally identifiable and publicly associated with the death of a suspect in their custody. Across the board, the rightwing press rehabilitated their reputations. The three officers had been victims of 'reverse discrimination'. They were 'too traumatised' to return to duty after having charges brought against them, had been unfairly professionally hobbled, argued the *Mail*, *Express*, *Telegraph*, *Daily Star* and the *Sun*. 'High flyer' Sergeant Linda Evans was able to tell in an interview of how her career path had been derailed by the 'show trial'.

This reverse discrimination thesis was central to the rightwing media's case that Joy Gardner was an undeserving claimant for justice. Simply bringing charges against the officers showed that the state had placed the demand for justice for a 'shanty town girl who bent the rules for a better life'[31] over and above justice for the 'superb detective' Linda Evans and her colleagues. The trial was cast as a betrayal of common-sense justice. '[T]he case should never have been brought to court', said the *Mail*.[32] The *Mail on Sunday*'s John Junor asked 'Why were they ever charged', while the *Sunday Express* claimed Evans'

'shameful treatment' was caused by 'black rights activists ... baying for her blood'.[33]

The rightwing media's argument went further, speculating that the trial would cause police officers to take too soft an approach on black people for fear of facing allegations of racism. The 'impulse, when things "go wrong", to pin the blame on those we send in to do our dirty work'[34] had potentially hamstrung future policing operations: 'the three officers have had their careers permanently damaged', said the *Spectator*. 'Other humble police constables will take note of that, and will tend to avoid trouble with blacks behaving unlawfully'.[35] Exactly the same specious argument was put forth by thinkers on the Right and their allies in the press in the wake of the shooting of Mark Duggan in 2011.[36]

Twenty-two years on

Little has changed since 1993. In 1999, the Met ascribed its use of force against Roger Sylvester to his 'exceptional strength',[37] while the now-discredited Home Office pathologist Dr Freddy Patel held an impromptu press conference at the opening of the inquest into Sylvester's death, branding him a crack user.[38] Sylvester had been suffering from mental health issues at the time of his detention. In 2003, Mikey Powell died following contact with West Midlands police officers. The 2009 inquest into his death was immediately followed by a report in the *Telegraph*, which claimed that the jury had cleared officers of culpability for his death and of racist policing (neither was the case), put forward the same argument as emerged following the acquittal of the officers in Gardner's case: that allegations of racism had hamstrung the police.[39]

In 2005, on the morning that armed police shot and killed Jean Charles de Menezes as part of a counter-terror operation, then Met Commissioner Ian Blair defended their actions at a press conference, telling reporters that 'the man was challenged and refused to obey police instructions'. Assistant Commissioner Andy Hayman was found by the IPCC to have constructed a misleading statement for the press, withholding the knowledge that de Menezes was innocent.[40] Scotland Yard, along with unnamed security services sources, put forth the claim that de Menezes was wearing a suspicious bulky coat on a hot summer day, that he vaulted the ticket barrier at Stockwell tube station and ran onto a train, and then stood up to confront police once they had made their presence known. The *Times* reported that after police told him to stop, Menezes 'looked over his shoulder and bolted',[41] while the *News of the World*'s two-page spread was headlined 'Why did he run?' and claimed that police were 'screaming for him to stop'.[42] It was later revealed that Menezes was wearing a light denim jacket, travelled through the station calmly (without jumping over the barrier), sitting in the first available seat, and was unaware that police were following him.[43] Witnesses later claimed that police had never identified themselves before shooting him.

And in 2011, in the immediate aftermath of the death of Mark Duggan, information that police had been involved in a 'shoot out' – an exchange of fire – was reported in the press, which appeared to come from the Independent Police Complaints Commission. This was proved untrue by the inquest into his death. Over the next two years, 'unnamed police sources' fed to the media accusations that Duggan was a known and dangerous 'gangster'. In story after story the same photo appeared, of Duggan the hard man, staring defiantly into the camera as if no one and nothing could touch him. Hidden by the head-and-shoulders frame, cropped from a larger photo, was the floral heart-shaped plaque he was holding in his hands, as he attended the grave of his still-born daughter. Not defiance, but grief.[44]

◆ ◆ ◆

References

1. It is significant that the most important work on deaths in custody has been done by freelance journalists and independent writers and film-makers, for example: Diane Taylor's work on deaths in detention; Tanika Gupta's play *Gladiator Games* on the death of Zahid Mubarek in Feltham young offenders' institution; *The Hounding of David Oluwale*, based on Kester Aspden's research; and Ken Fero's seminal film *Injustice*, along with many others by the Migrant Media collective on family campaigns for justice after the death of a loved one in police custody.
2. This is spent on supporting a 24-hour press bureau and four teams of specialist press officers; marketing campaigns; internal campaigns; and external relations with corporate stakeholders. Information obtained from FOI requests received 15 May 2014. Thanks to Vincent Callaghan.
3. 'The inaccurate police account of how newspaper-seller Ian Tomlinson died during the G20 protests in London in 2009 was at first swallowed whole by the bulk of the media ... The key amateur footage that disproved the police line was sent to *Guardian* journalist Paul Lewis largely because he had already shown himself willing ... to question the police version of events.' Tony Harcup, 'Reporting the Next Battle: lessons from Orgreave', in *Settling Scores: the media, the police and the miners' strike* (London, Campaign for Press and Broadcasting Freedom, 2014), pp. 95-105.
4. See Nick Davies, *Flat Earth News* (London, Vintage, 2009).

5. *Evening Standard* (10 August 1993).
6. *Sunday Times* (8 August 1993); *Evening Standard* (10 August 1993); *Telegraph* (4 August 1993); *Independent* (6 August 1993).
7. *Daily Express* (9 August 1993).
8. *Daily Star* (5 August 1993).
9. *Sunday Times* (8 August 1993).
10. *Daily Mail* (4 August 1993).
11. *Daily Mail* (5 August 1993). The *Evening Standard* reported that Mr. Gardner had demanded £5,000 before talking to them, which they refused. He 'received a substantial sum of money for his story from a Sunday newspaper' (13 August 1993).
12. For example, Joseph Gardner claimed that Joy's own mother, Myrna Simpson, would not live with her because of her 'violent behaviour'. Simpson vehemently rejects the claim, along with the suggestion that the marriage was a sham. For more information, see 'Did justice die along with my daughter?', *Independent* (26 August 1993). See also an interview with Joy's friend Nellie Sterling, in which she claimed that Joy's husband forced her to 'choose between keeping her marriage or keeping her son'; quoted in 'The lies being spread about my friend Joy', *Evening Standard* (13 August 1993).
13. *News of the World* (8 August 1993).
14. *Evening Standard* (6 August 1993).
15. David Leppard in *Sunday Times* (8 August 1993).
16. Lest we forget, it was under Condon's tenure that officers from the Met's Special Demonstrations Squad went undercover to spy on the grieving family of murdered black teenager Stephen Lawrence. For more information, see Rob Evans and Paul Lewis, *Undercover: the true story of Britain's secret police* (London, Faber & Faber, 2013).
17. 'We're not to blame blast death cops', *Daily Star* (11 August 1993); 'We're scapegoats, say suspended officers', *Daily Mail* (11 August 1993); 'Our struggle with deportee Joy, by suspended police' *Daily Express* (11 August 1993); 'How Joy Gardner died, by mystery "go between"', Today (11 August 1993); *The Sun* (15 August 1993).
18. *The Sun* (15 August 1993).
19. See, for example, 'Gagged deportee "was suffocated"', *Guardian* (11 August 1993).
20. Richard Littlejohn, 'Barmy Bernie and a dose of the Trots', *Sun* (5 August 1993).
21. Described in *The Sun* (6 August 1993). Littlejohn's attitude provoked calls for a boycott of his 'dangerous and pernicious' coverage.
22. See David Rose, *A Climate of Fear: the murder of PC Blakelock and the case of the Tottenham Three* (London, Bloomsbury, 1992).
23. David Rose and Lesley Gerard, *Observer* (8 August 1993).
24. *Daily Mail* (27 April 1994).
25. Richard Littlejohn, *Daily Mail* (16 June 1995).
26. Leo McKinstry, *Sun* (16 June 1995). McKinstry later led a backlash against the MacPherson report's landmark finding of institutional racism in the police while working at the *Telegraph*. Now, as a columnist for the *Daily Express*, he campaigns for the repeal of the Human Rights Act, the deportation of foreign national prisoners and the end of 'mass immigration'. See 'The Press, the police and MacPherson, *CARF* (No. 49, April-May 1999); and John Grayson, '"Veto nationalism": populism, nationalism and the Tories', IRR News (11 January 2012). See also Jon Burnett, 'When class becomes a commodity', IRR News (4 September 2014).
27. See, for instance, Cecil Gutzmore, 'Capital, "black youth" and crime', *Race & Class* (Vol. 25, 1983).
28. 'No justice for Joy', *CARF* (No. 27, August-September 1995).
29. *Daily Mail* (20 May 1995).
30. *Spectator* (24 June 1995).
31. *Daily Mail* (15 June 1995).
32. Richard Littlejohn, *Daily Mail* (16 June 1995).
33. John Junor, *Mail on Sunday* (18 June 1995); David Evans, *Sunday Express* (18 June 1995). While editor of the *Sunday Express*, Junor reportedly refused to publish an interview with the prominent gay African American author, James Baldwin, on the grounds that he was a 'black pervert'. See Graham Lord, *Press Gazette* (10 April 2013).
34. *Daily Express* (15 June 1995).
35. *Spectator*, op. cit. The article went further with its accusation that the police had been hobbled by a misguided politically-correct elite: 'It is no secret, for instance, that black crime is increasing. Of course you cannot prove it, as statistics are deliberately concealed by scared or political [sic] correct authorities. But it seems to be a fact.'
36. *Mind-Forg'd Manacles*, for example, by rightwing think-tank Civitas, claimed that political correctness had forced the Metropolitan police to acquiesce to black people's 'grievance', which 'demanded the right not to be policed'. The report, which prompted a feature in the *Daily Mail* (6 August 2012), was published 12 months after Met officers shot and killed Mark Duggan. For further discussion, see Ryan Erfani-Ghettani, 'Did Macpherson manacle the police?', *IRR News* (13 September 2012).
37. *Black deaths in police custody: the story of Roger Sylvester 1968-1999*, INQUEST.
38. Harmit Athwal, 'Roger Sylvester – police condemned for black death', IRR News (9 October 2003).
39. Betsy Barkas, 'Powell family's police complaint upheld', IRR News (7 November 2013); Alasdair Palmer, 'The Michael Powell case shows how charges of racism hobble the police', *Daily Telegraph* (19 December 2009).
40. *Stockwell Two: An investigation into complaints about the Metropolitan Police Service's handling of public statements following the shooting of Jean Charles de Menezes on 22 July 2005*, Independent Police Complaints Commission (July 2007). Andy Hayman was in charge of the initial inquiries into alleged phone hacking at the *News of the World*. In 2009 he concluded that no investigation was needed, despite the Met's possession of the notebooks of Glen Mulcaire, which detailed a history of hacking offences and implicated nearly thirty News International journalists in the practice. Hayman later left the police to work for News International as a columnist.
41. *Times* (23 July 2005), accessed via Spinwatch's online *Powerbase* resource: <powerbase.info>.
42. *News of the World* (24 July 2005).
43. 'New claims emerge over Menezes death', *Guardian* (17 August 2005).
44. For an account of Mark Duggan's death and the misinformation that was spread in the aftermath, see Betsy Barkas, 'Framing the death of Mark Duggan', IRR News (17 April 2014).

Appendix I

Statistical analysis of cases

Jon Burnett

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Overview

This report features the cases of 509 people from BME, asylum seeker and migrant communities who have died in custody, in suspicious circumstances, between 1991 and September 2014. On average, this is about 21 deaths per year. The majority of the deaths documented – 348 (68 per cent of the total) – took place in prison; 137 cases (27 per cent) were in police custody and 24 cases (5 per cent) were in the immigration detention estate (including immigration removal centres and short-term holding facilities). As Figure 1 shows, in 2007, there were 49 suspicious deaths – the highest number recorded.

FIGURE 1

Number of deaths per year

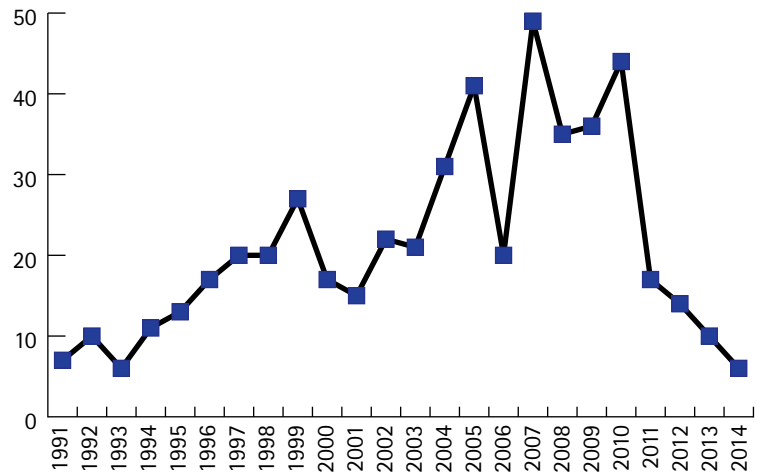
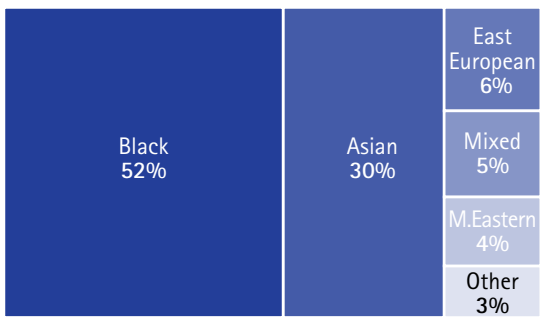


FIGURE 2

Ethnicity of those who died in custody



Profile

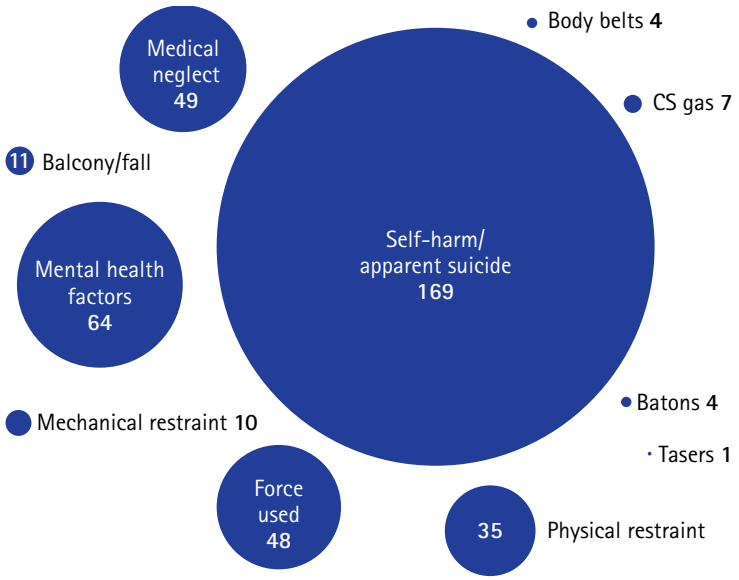
Of the cases that we have monitored, 478 (94 per cent of the total) people were male, and 31 (6 per cent) people female. Just over half of the people whose cases are featured were black or black British. (See Figure 2)

Contributory factors

One-in-three of the total deaths (169, or 32 per cent) we documented were apparent suicides, or as a result of self-harm. (See Figure 3) In 64 of the total cases (13 per cent) the person who died had known mental health problems. Medical neglect was a contributory factor in 49 of the total number of cases (10 per cent) and in 48 of the cases (9 per cent) the use of force appears to have contributed to the person's death.

FIGURE 3

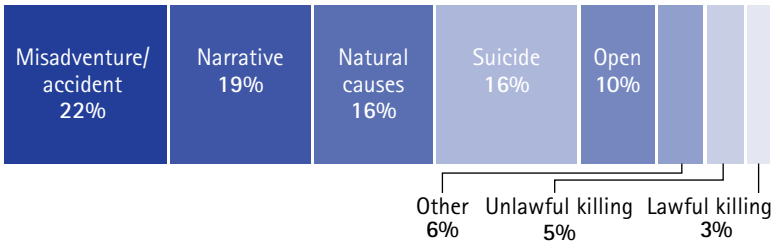
Contributory factors to custody deaths



Note: the number of contributory factors will not add up to the total as there could be more than one contributory factor per person.

FIGURE 4

Known inquest verdicts



Inquest verdicts

As shown in Figure 4, ten of the deaths we documented (5 per cent) were followed by an unlawful killing verdict as a result of an inquest. Two of these verdicts were overturned on appeal. In the majority of the cases (60 per cent) featured, the inquest verdict is unknown to us. (There is no register of all inquest verdicts available to the public.)

Police deaths

Overview

Of the 137 people who died as a result of police contact, 126 (92 per cent) were male and 11 people (8 per cent) female. Seventy-eight people (57 per cent) were Black or Black British, and 31 (22 per cent) were Asian or Asian British.

FIGURE 5

Ethnicity of those who died during or following police contact

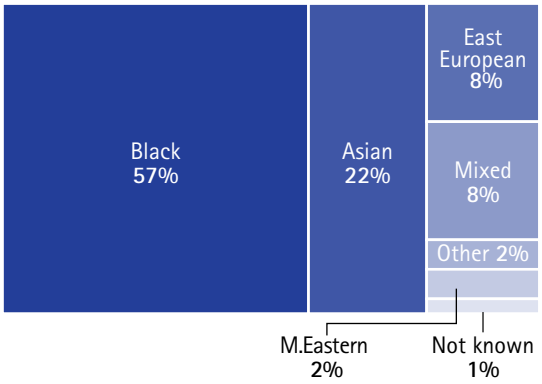
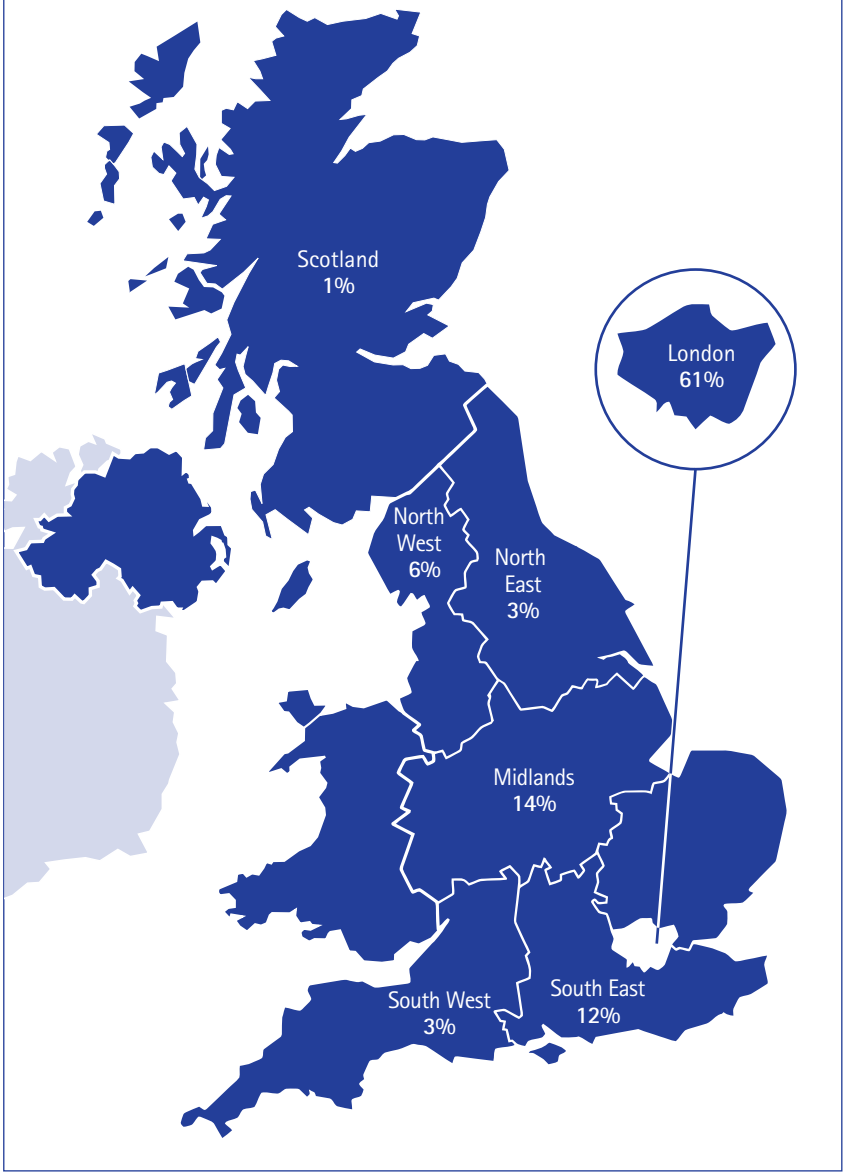


FIGURE 6

The geographic location of those who died following police contact



Geography

The cases are concentrated predominantly in London, where 61 per cent died. Around one in three of those who died during or following police contact (17 people, or 12 per cent) lost their lives in the South East outside London. Nineteen people (14 per cent) died in the Midlands.

Place of death

Just over a third of those who died following police contact died whilst in a police cell or station (51 people, or 37 per cent), and slightly fewer people died on the streets (49 people, or 36 per cent). A breakdown of this is provided in Figure 7, which also shows that 17 people (12 per cent of the total) died in their homes, during police raids, after police visited them in their homes or after some other form of police contact.

FIGURE 7

Place of death following police contact

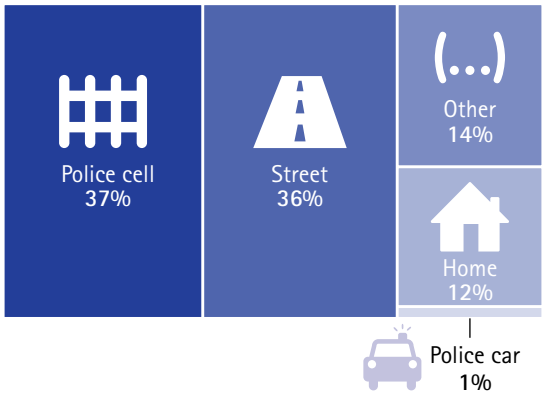
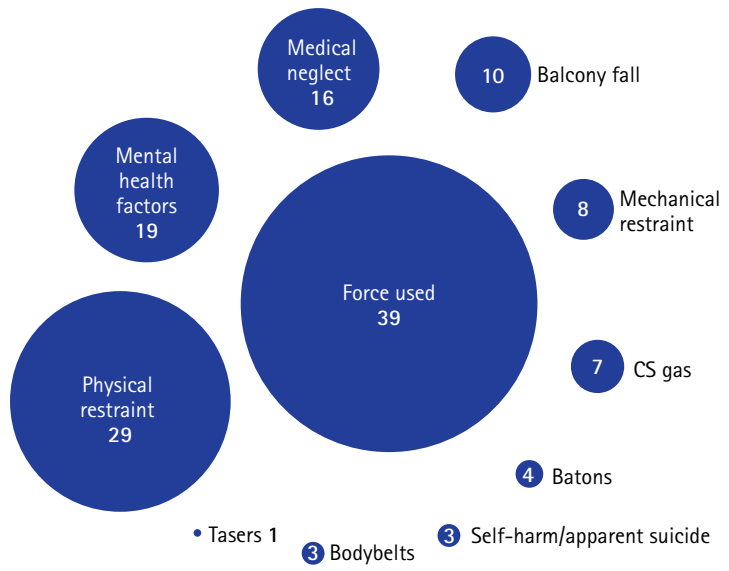


FIGURE 8

Factors contributing to deaths following police contact



Note: the number of contributory factors will not add up to the total as there could be more than one contributory factor per person.

Contributory factors

Fewer than half of those who died following police contact – 61 people, or 45 per cent – were arrested before their death. Nine of the 137 (7 per cent) had been detained under the Mental Health Act. Thirty-four people died as a result of a police chase, and 6 people (4 per cent) died in incidents after being stopped and searched.

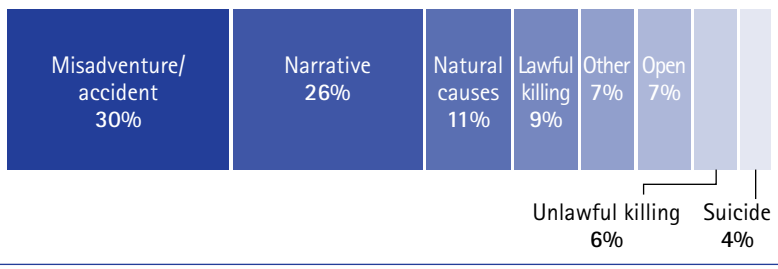
The use of force by the police contributed to the deaths of 39 people. And 29 deaths were linked to the use of physical restraint. Seven people's deaths were linked to the use of CS gas by the police and in 10 of the cases the person died after falling from a balcony, at times trying to escape from the police. (Figure 8)

Inquest verdicts

Inquest results are not known to us in 67 (49 per cent) of the cases. In 21 cases (15 per cent of the known cases), the inquest returned a verdict of misadventure/accidental death. Four of the inquest verdicts were unlawful killing, and six were lawful killing. (Figure 9)

FIGURE 9

Known inquest verdicts in deaths following police contact



Prison deaths

Overview

As stated above, 348 deaths (68 per cent of the total) – took place in prison. Of these, 332 people (95 per cent) were male and 16 (5 per cent) female. The breakdown of ethnicity of those who died in prison broadly matches that of the cases as a whole. Fifty-one per cent of those who died in prison were black or black British. Thirty-three per cent were Asian or Asian British. (See Figure 10)

FIGURE 10

Ethnicity of those who died in prison

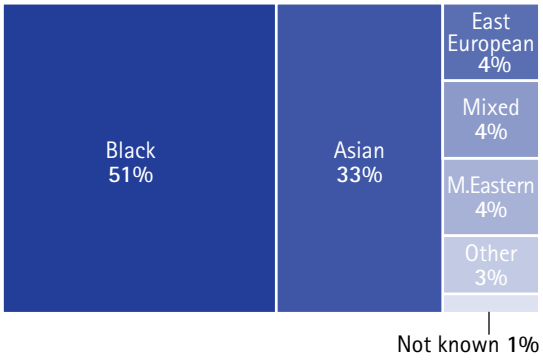
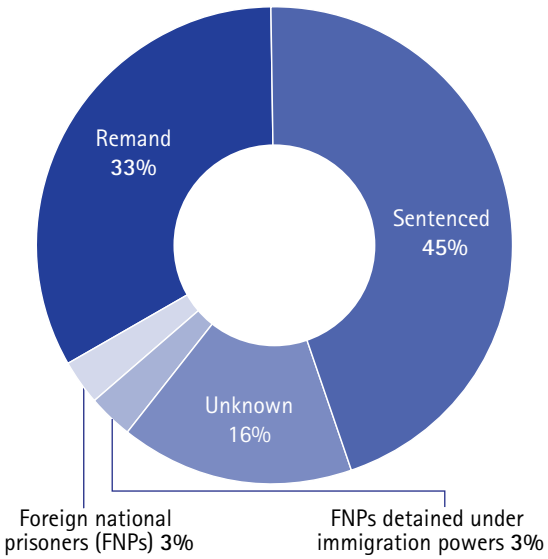


FIGURE 11

The status of those who died in prison



Prisoner status

Of those who died in prison, almost half (45 per cent, or 158 people) had been sentenced for a criminal offence and a further 113 people (33 per cent) were on remand, awaiting trial. (See Figure 11) Twenty-three were foreign national prisoners of whom 11 were serving sentences and 12 more detained after sentence under immigration powers.

Prisoner location

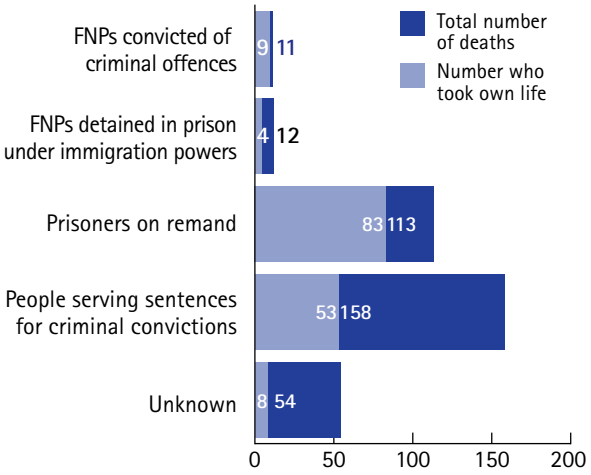
The prisons where most deaths took place were HMP Wormwood Scrubs and HMP Pentonville (18 people died in both). Seventeen people died in HMP Wandsworth, 14 in HMP Brixton and 13 in HMP Belmarsh. Ten people died in HMP Leeds, 8 in both HMP Manchester and HMP Winchester and 7 in each of HMP Birmingham, Frankland, Nottingham, Norwich and Leicester.

Contributory factors

According to our records, nearly half of those who died in prison – 157 people or 45 per cent of the sub-total – took their own life or died as a result of self-harm. In particular circumstances, however, the proportion of prisoners who took their own life increased substantially. Of the 113 people who died while on remand, 83 (77 per cent) took their own life. Nine of the 11 foreign national prisoners who died (82 per cent) took their own life. (See Figure 12) Of the 348 cases involving deaths in prisons, according to our records, medical neglect was a contributory factor in 28 (8 per cent of the total). In 41 cases (12 per cent), our records indicate that mental health was a factor in the death.

FIGURE 12

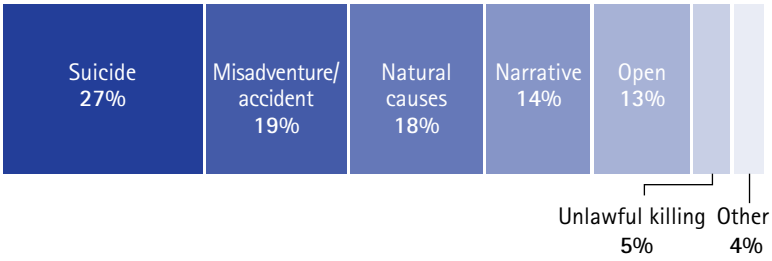
Status of prisoners who took own life or died as result of self-harm



FNP = foreign national prisoner

FIGURE 13

Known inquest verdicts into prison deaths



Inquest verdicts

In the majority of cases we recorded (224, or 64 per cent), the inquest verdict was not known to us. Of those known to us, inquests returned suicide verdicts in 34 cases, and misadventure/accident verdicts in 23 cases. In 22 cases, the inquest ruled that the person had died of natural causes. (See Figure 13)

Immigration deaths

Twenty-four of the deaths took place in immigration detention, shortly following detention or during a deportation. Of the 22 deaths in detention or shortly afterwards, about one-third were in Harmondsworth immigration removal centre. (See Figure 14)

FIGURE 14

Location of deaths in immigration detention

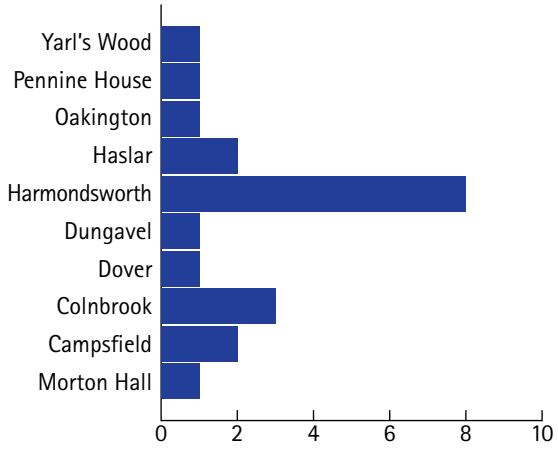
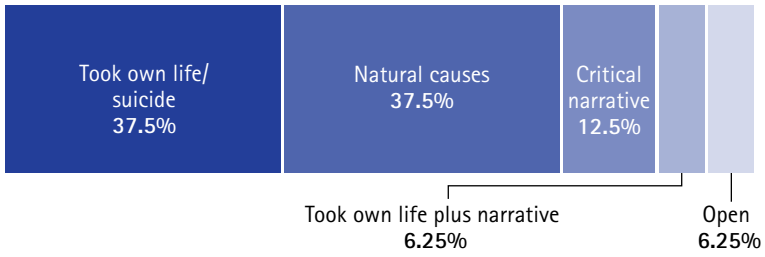


FIGURE 15

Inquest verdicts into deaths in immigration detention



Inquest verdicts

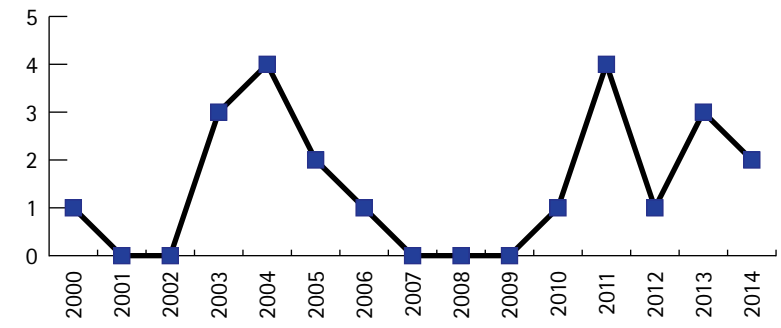
Of the 22 deaths in detention, or shortly afterwards, we are aware of inquest verdicts in 16 cases. In 7 of these, the inquest ruled that the person took their own life. (See Figure 15) At least 9 of these 22 deaths involved a pre-existing medical condition or were related to a medical condition that occurred during detention.

Deaths by year

Deaths by year (excluding those who died during attempted removals) are shown in Figure 16.

FIGURE 16

Deaths in immigration detention by year



Note: Excludes deaths during deportations

FIGURE 17

Country of origin of those in immigration-related deaths

Appendix II

One death is a death too many

A. Sivanandan

We reproduce below the introduction to Deadly Silence: black deaths in custody *(IRR, 1991), written by A. Sivanandan, who is Director Emeritus of the Institute of Race Relations.*

TOO MANY OF us have died without cause, since first we came to work for this country in the post-war years, in the custody of the police, the prison system and the special hospitals. Or if cause there be, common to all three, it is the racist bias that has been woven into, and become an inextricable part of, the culture and administration of these 'services'.

That is not to say that all wrong-doers, prisoners and psychiatric patients are not a citizenry apart, but that black wrong-doers, prisoners, psychiatric patients are, by virtue merely of their blackness, rendered an under-class of that already under-privileged citizenry. Black vagrants are even more readily than their white counterparts the sport and playthings of macho white policemen. Young blacks are frequently stopped and questioned on the basis of no more than a generalised suspicion that if they are black and young and on the streets they can be up to no good. And the way that blacks are subjected to violent arrest stems from another presumption: that blacks are violent and aggressive by nature and must, from the outset, be dealt with violently and aggressively. Violence is the only language they understand, and it is time they knew who was boss.

The contempt for blacks on the streets is carried into the contempt for blacks in their homes, for black family life. The black man's home is not his castle, even less the black woman's hers. There is nothing inviolable about the black family.

And prisons presume those presumptions: the statistics tell them that all blacks are potential criminals, the sentencing carries the conviction, it is no longer a matter of prejudice. The proof is in the numbers. The system is justified, it closes in on itself, it brooks no interference from outside – the indifference to black life becomes a fact of prison life. Suicide offers the only release.

If prisons are of their very nature closed-in systems, special hospitals are the demesne of the specialists – and to question their diagnosis of the 'mentally ill' is itself an act of madness. And yet, when it comes to young black men, the evidence is of a marked tendency towards diagnoses based on racial stereotypes rather than on individual case histories.

Racial diagnosis, it would appear, over-rides clinical diagnosis. Thus, young Afro-Caribbeans, who exhibit what is considered odd or antisocial behaviour, are commonly diagnosed as schizophrenic – schizophrenia being the disease that blacks are supposed to suffer from disproportionately, either because of some genetic reason or because West Indian family and/or child-rearing patterns create a cultural or ethnic deficit amongst black people as a whole. Little attempt is made to seek the cause of the 'patient's' behaviour in his (and invariably it's a he) particular history or the anomie visited on him by a racist society. Instead, the 'illness' which might well have been caused by the individual's inability to bear the brutal brunt of racism is further compounded by the racism implicit in the diagnosis and cure. And, so far from getting the care he needs, the patient is even further entered into a syndrome of un-caring from which his 'illness' first sought escape. The only escape now is the last. The cycle of discrimination, deprivation and death is complete.

But how do the police, the prisons and the special hospitals get away with it year after year? How does the bias against blacks work itself into the system? How does the culture of racism become policy?

To one extent or another, each of these services is unaccountable to the public in one way or another. And to the extent that they are unaccountable, inaccessible, specialised, to that extent is their power made more absolute. When such institutional power sediments into the hands of individual policemen, prison officers, hospital warders, the service becomes sclerosed against the public.

The structure of the services themselves further adds to that hardening. Ranked, like the army, in a strict hierarchy of command, they too tend to cultivate an ethos of phoney camaraderie by closing ranks when under attack. In the event, the chain of command becomes a chain of cover-up.

To the extent that the police are more immediately in the community, they are that much more vulnerable to public censure. But the lack of an independent complaints system has hindered a real and continuing openness to public scrutiny, never mind accountability, and led instead to the setting up of cosmetic race relations committees (to show 'liaison') and to public relations exercises (to forestall criticism). The public, however, and the black communities in particular, continue to break into this closed system with pickets and protests and people's inquiries.

Prisons and special hospitals, on the other hand, are a world apart, where the wardens are kings and the governor plays God over the lives of prisoners – moving them around as they please, deciding their present and future condition, withholding and affording medical treatment as suits their whim and driving them into insensibility through drugs rather than bringing them to their senses through therapy. Where the Board of Visitors is a sop to Cerberus and prisoners themselves may not bear witness to their condition lest their condition is made to worsen. Where none may enter except through the Home Office – and none may question except through the Home Office. Where, precisely because these are closed-in, unaccountable, hermetically sealed systems, racism goes unchallenged and fascism parades among the guards. Where black suicide is a cold statistic.

And the inquests afford no relief. The coroner is there to tell you the facts of death, not who was responsible for it or why. But even the facts are loaded against you. For the coroner's court is not an adversarial court where you have an equal chance to challenge the authorised version of the facts. Instead, it is the coroner who, aided by the police, is both judge and advocate, and controls the proceedings of his court. He alone has access to vital information stemming from an internal inquiry, but he is not obliged to divulge it. He alone decides which witnesses to call and in what order the evidence should be presented. He alone sums up and directs the jury, leads them – and tells them to choose from a restricted range of four verdicts, only one of which, 'unlawful killing', allows the relatives of the deceased a real chance to reopen the case with a view to prosecution and/or compensation. But such a direction to the jury is observed more in the breach.

Out of 75 cases of black deaths in custody recorded here, only one has resulted in a prosecution (of the police) and only in one has the family of the deceased received compensation.

The rest is silence. Black deaths do not have a good press, especially when they occur in the custody of our custodians. The media leads the public to believe that our guardians can do no wrong. Racism leads them to believe that blacks can do no right. The silence of the custodial system is compounded by the silences of racism.

We have chosen to break that silence.

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Appendix III

Resources

Family campaigns

Justice for Ricky Bishop
Facebook: https://www.facebook.com/groups/41965963816/

Justice for Leon Briggs
Facebook: https://www.facebook.com/justice4leonbriggs
Twitter: @JusticeLeon1

Justice for Kingsley Burrell
Facebook: https://www.facebook.com/Justice4Kingsley
Twitter: @March4Justice

Campaign for Justice for Smiley Culture
Facebook: https://www.facebook.com/Campaign4Justice4SmileyCulture

Justice for Mark Duggan
Website: http://justice4mark.com
Email: justiceformarkduggan@gmail.com
Facebook: https://www.facebook.com/pages/Justice-for-Mark-Duggan/531975963519194
Twitter: @justice4mark

Justice 4 Anthony Grainger
Website: http://justice4grainger.wordpress.com
Email: justice4grainger@yahoo.com
Facebook: https://www.facebook.com/groups/justice4grainger/

Justice for Seni. The Olaseni Lewis Campaign For Justice and Change
Website: http://www.justiceforseni.com
Email: info@justiceforseni.com

Justice for Philmore Mills
Facebook: https://www.facebook.com/pages/Justice-for-Philmore-Mills/187052198063547

Friends of Mikey Powell Campaign For Justice
Website: http://mikeypowell-campaign.org.uk
Tel: 0843 289 8535 (leave a callback message)
Facebook: https://www.facebook.com/events/353708191426588/

Sean Rigg Justice & Change Campaign
Website: http://www.seanriggjusticeandchange.com

Azelle Rodney Campaign for Justice
Website: https://azellerodneycampaignforjustice.wordpress.com
Inquiry website: http://azellerodneyinquiry.independent.gov.uk
Facebook: https://www.facebook.com/susiea81

Justice For Habib 'Paps' Ullah
Website: http://justice4paps.wordpress.com
Tel: 07766 464 358 or 07869 360 377
Email: justiceforpaps@aim.com
Facebook: https://www.facebook.com/Justice4Paps
Twitter: @Justice4Paps

Advice & campaigning organisations

4WardEver UK
News and information service on deaths in custody issues.
Website: http://4wardeveruk.org
Tel: +44 0843 289 4994
Twitter: @4WardEver

INQUEST
Charity providing specialist advice to people affected by deaths in custody.
Website: http://www.inquest.org.uk/about/home
Tel: 020 7263 1111
Facebook: https://www.facebook.com/inquestUK
Twitter: @INQUEST_ORG

Medical Justice
Organisation promoting the health rights, and associated legal rights, of immigration detainees in the UK.
Website: http://www.medicaljustice.org.uk
Email: (Referral inquiries) med@medicaljustice.org.uk
(General inquires) info@medicaljustice.org.uk
Tel: 020 7561 7498

Migrant Media
Migrant media is a group of political film-makers. Its films include:
Po Po: *A short documentary on Jason McPherson who died in police custody in Notting Hill.*
Justice Denied: *A film about Joy Gardner who died in 1993 after police officers and deportation officers restrained her using a body belt, ankle straps and gagging her mouth with thirteen feet of tape.*
Who Polices the Police?: *A documentary about the flawed investigation by the IPCC into the death of Sean Rigg whist in police custody.*
Injustice: *A film documenting the struggles of families of people who have died in police custody.*
Website: http://www.injusticefilm.tv/ or http://www.injusticefilm.co.uk/
Email: info@injusticefilm.co.uk
Tel: 07770 432 439
Vimeo: http://vimeo.com/user6137135
Twitter: @kenfero

United Family and Friends Campaign
A coalition of families and supporters affected by deaths in custody.
Tel: 07770 432 439
Email: contactuffc@gmail.com
Facebook: https://www.facebook.com/pages/United-Families-Friends-Campaign-UFFC/308702409174443
Twitter: @UFFCampaign

Governmental organisations

Crown Prosecution Service (CPS)
The CPS is responsible for criminal prosecutions in England & Wales.
Website: http://www.cps.gov.uk/
Tel: 020 3357 0000
Email: enquiries@cps.gsi.gov.uk
Twitter: @cpsuk

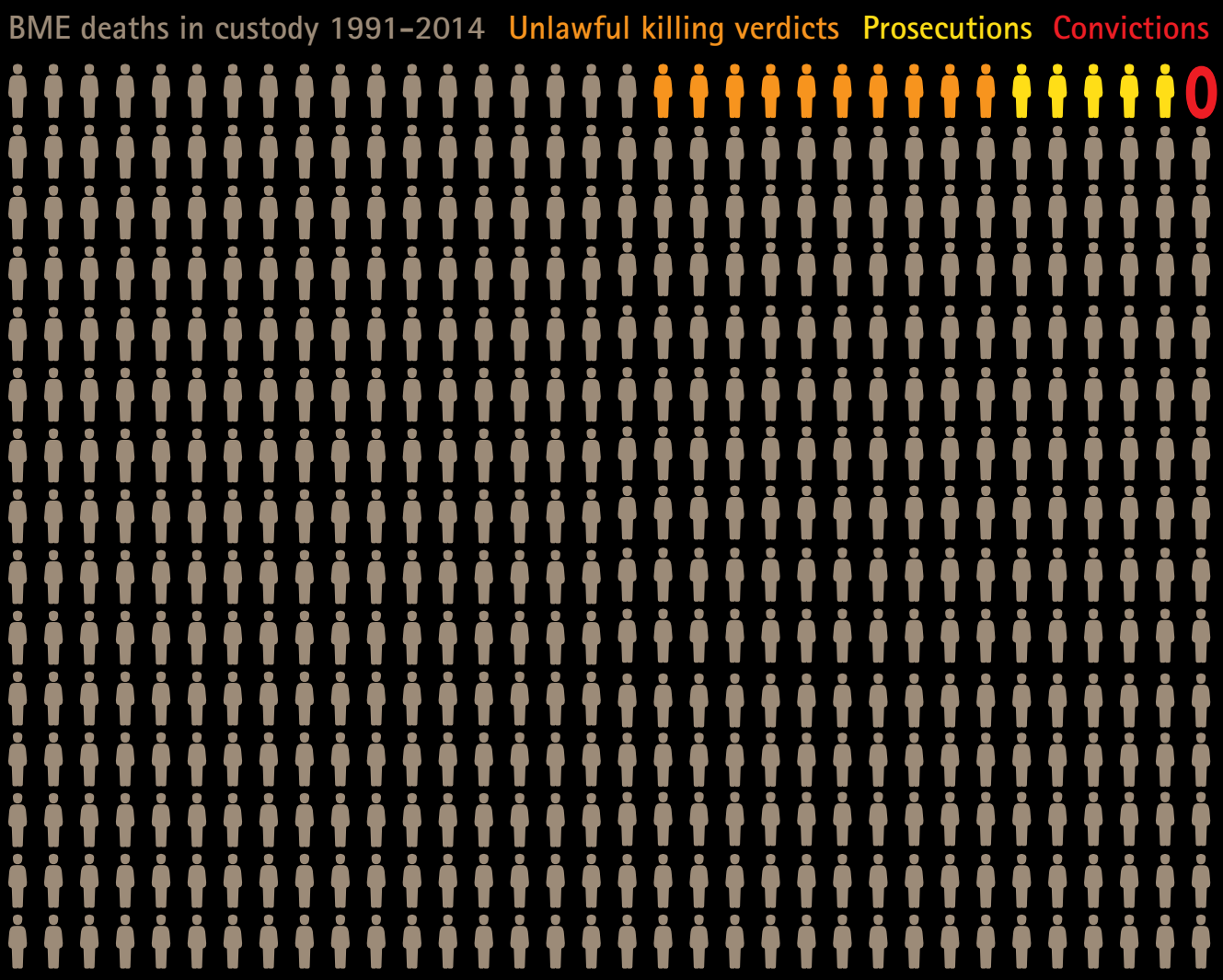
HM Inspectorate of Constabulary (HMIC)
HMIC assesses police forces and policing.
Website: http://www.justiceinspectorates.gov.uk/hmic/
Tel: 020 3513 0500
Email: contact@hmic.gsi.gov.uk
Twitter: @HMICgov

HM Inspectorate of Prisons (HMIP)
HMIP for England and Wales reports on conditions for and treatment of those in prison, young offender institutions, secure training centres, immigration detention facilities, police and court custody suites, customs custody facilities and military detention.
Website: https://www.justiceinspectorates.gov.uk/hmiprisons/
Tel: 020 3681 2770
Email: hmiprisons.enquiries@hmiprisons.gsi.gov.uk
Twitter: @HMIPrisonsnews

Independent Police Complaints Commission (IPCC)
Body dealing with complaints made against the police.
Website: http://www.ipcc.gov.uk
Tel: 0300 020 0096
Email: enquiries@ipcc.gsi.gov.uk
Facebook: https://www.facebook.com/pages/IPCC-Independent-Police-Complaints-Commission/105248346269780
Twitter: @IPCCNews

Prison and Probation Ombudsman
Body investigating complaints made by prisoners, people on probation and immigration removal centres.
Website: http://www.ppo.gov.uk
Tel: 020 7633 4100
Email: mail@ppo.gsi.gov.uk
Facebook: https://www.facebook.com/pages/Prisons-and-Probation-Ombudsman/135755996455883

Index to cases



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