UNITED KINGDOM
Deaths in custody: lack of police accountability

1. Introduction

Since the early 1990s, Amnesty International has been monitoring the cases of people who died in police custody in England and Wales. In particular the organization has focussed on those cases in which people died after being allegedly ill-treated and/or subjected to excessive use of force while being restrained by police officers during arrest or in police custody. There have also been instances where the inadequacy of the treatment received by individuals while in police custody has led to allegations of neglect.[1] A high proportion of these cases have been of people from black or ethnic minority communities. The different incidents illustrated concerns about the use of methods of restraint, including US-style batons and CS gas; and restraint techniques resulting in deaths caused by positional asphyxia[2].

Amnesty International is concerned that the authorities have failed to carry out independent and impartial investigations into the full circumstances of each death in custody; to make the results of investigations public; to bring to justice those alleged to be responsible; to provide reparation to the families of the deceased; and to ensure that all measures necessary are taken to prevent such incidents, including proper training in restraint techniques.

Sixty-five people died in police custody in England and Wales in the year ending March 1999, of whom several died in disputed circumstances.

[1] This could either be in the form of failing to provide adequate medical attention or to carry out resuscitation; or the failure to deal in an appropriate manner with people who have psychiatric conditions.

[2] *Unlawful killing of detained asylum-seeker Omasese Lumumba*, November 1993, AI Index EUR 45/13/93; *Death of two men while in the custody of London Metropolitan Police* (Brian Douglas and Shiji Lapite), July 1995, AI Index EUR 45/04/95; *Death in police custody of Joy Gardner*, August 1995, AI Index EUR 45/05/95; *Summary of human rights concerns*, August 1995, AI Index 45/06/95; *Unlawful killing of Richard O'Brien*, March 1996, AI Index EUR 45/06/96; *Death in custody of Ibrahima Sey*, October 1996, AI Index EUR 45/15/96; *Briefing for the Committee Against Torture*, November 1998, AI Index EUR 45/23/98.

The organization has identified a pattern of deaths in custody as a result of law enforcement officials' use of restraint techniques which has led to positional asphyxia. There has been a decline in cases where the use of "neck-holds" to restrain someone may have contributed to the death.[3] The use of the neck-hold resulted in the death of Shiji Lapite, of Nigerian origin, who died within minutes after arrest by police in London in December 1994. An inquest jury reached a unanimous verdict of "unlawful killing". Shiji Lapite had been arrested for "acting suspiciously". During the violent struggle to restrain Shiji Lapite, the two arresting officers twice kicked him in the head with great force, bit him and restrained him using the neck-hold. His body went limp and he died. The pathologists' reports indicated that Shiji Lapite had suffered between 36 and 45 separate injuries to his body, including a crushed larynx, and that he had died of asphyxiation.

However, the organization continues to be concerned at the use of other restraint techniques which can lead to positional asphyxia. According to the 1999 Police Complaints Authority (PCA) report, "Deaths in custody: reducing the risks", such methods of restraint involve a high element of risk. Their use can be as a result of police officers not receiving proper training, which can lead to officers not being aware of the risks of such techniques, or which can lead to police officers using unauthorized techniques of restraints. In other cases, deaths in custody have been as a result of an excessive use of force by officers, i.e. force which is disproportionate to any threat posed. The organization has repeatedly urged the authorities to review all restraint techniques used by law enforcement officials, and to ensure regular and repeated training about the dangers of positional asphyxia and in alternative methods of restraint.

Positional asphyxia, also known as restraint asphyxia, has been defined by the (US) National Law Enforcement Technology Centre "as death as a result of body position that interferes with breathing".[4] According to experts, it arises from use of neck-holds which restrict breathing or when a person is laid on their stomach during restraint and/or transportation. This position compromises a person's ability to breathe. Handcuffing a person behind their back also restricts a person's ability to breathe.[5] Any weight applied to the back in this position (such as pressure by a law enforcement officer, including an attempt to keep a person still) increases breathing difficulty further. A "natural reaction" to oxygen deficiency is increased physical struggle. In the face of such a struggle a law enforcement official is likely to apply additional pressure/compression to subdue the restrained

[3] The deaths of Brian Douglas and Gary Allsopp raised concerns about the use of the batons; and the death of Shiji Lapite raised concerns about the use of the "neck-hold" as a restraint technique. (See AI Index: EUR 45/23/98)

[4] "Positional Asphyxia - Sudden Death", National Law Enforcement Technology Centre, (a US national Institute of Justice Program), June 1995

[5] A forensic pathologist reportedly testified, during the inquest into the death of Wayne Douglas, that placing a person face down on their stomach with their hands cuffed behind their back is the "classic" position for positional asphyxia (AI Index 45/06/95).

person, yet further compromising the restrained person's ability to breathe. Factors which may increase dangers of positional asphyxia include: obesity; enlarged heart; alcohol and drug use or other things that impede the ability to breathe including, for example, the presence of chemical agents. Guidelines to minimize the risk of positional asphyxia include restraining a person other than laying them on their stomach and monitoring the restrained person's breathing and health.

Amnesty International has taken up a number of cases in which positional asphyxia was a cause of death. Richard O'Brien died of "postural asphyxia" in 1994 after London police officers pushed him to the ground, handcuffed him behind his back, and then one officer knelt on his back. He died within 10 minutes of his arrest. Thirty-one separate areas of injury to Richard O'Brien's body were identified in the post-mortem examination, including extensive cuts and bruises to his face, a damaged tooth, fractured ribs and torn muscles. The Coroner at the inquest into his death was critical of police training on methods of restraint; the jury returned a verdict of "unlawful killing". The subsequent prosecution of officers for manslaughter resulted in the acquittal in 1999 of the officers.

The Director of Public Prosecution's (DPP's) failure to bring prosecutions in the cases of Richard O'Brien and Shiji Lapite, after inquest juries returned verdicts of "unlawful killing", was challenged in the High Court in July 1997 by lawyers acting for the families. The DPP admitted flaws in the process of making decisions concerning prosecutions of police and agreed to review the decisions in these cases. In addition, an independent inquiry was initiated in July 1997 to examine the handling by the Crown Prosecution Service of deaths in custody and related matters. The inquiry, which was carried out by retired Judge Butler, made recommendations for change in how the prosecution authorities dealt with deaths in custody cases (see page 10 for further details).

As a result of monitoring the deaths in custody cases, Amnesty International has concluded that the government has failed to ensure the protection of the internationally recognized fundamental right to life.[6] A pattern has emerged of the authorities' failure, in England and Wales, to take measures to prevent deaths in custody as well as to carry out impartial and effective investigations into such deaths and to hold people responsible for such deaths. The authorities have also failed to investigate thoroughly and to hold police officers responsible for acts of ill-treatment. These failures have contributed to the perception that law enforcement officials can act with impunity. There has also been an erosion of public confidence in the justice system.

[6] In the 1999 PCA report, "One year on, deaths in police custody: the risks reduced", the PCA refers to the judgment of the European Court of Human Rights in *McCann and Others v the UK*, stating that the Court's interpretation of the scope of Article 2 of the Convention, on the right to life, puts a duty on a police force to improve systems that have failed to protect life in the past and to provide adequate training for officers and systems and medical care for the preservation of life of incapacited prisoners (Case 17/1994/464/545, Strasbourg, 27 September 1995).

This paper describes several deaths in custody in detail, and then addresses some of the systemic problems which need to be urgently addressed by the government. In preparation for this report, the organization sought information from lawyers of victims' families, academic lawyers, non-governmental organizations including the key London-based organization "Inquest", public authorities and press reports.

2. Individual cases

2.1. Glenn Martin Howard

On 8 December 1997, Glenn Martin Howard was admitted to a mental health hospital in Sutton, South London, under Section 135 of the Mental Health Act 1983. He had a long history of schizophrenia and was in need of treatment at the time.

On 10 December 1997, sometime between 6.30pm and 7.30pm, Glenn Howard left the hospital. On previous occasions, when he had been treated at the same hospital, he was known to have left the hospital to return to his flat to feed his tropical fish, but then to return. At 7.30pm, on the evening of 10 December 1997, a nurse at the hospital contacted Sutton Police Station to report him missing. Two police officers came to the hospital and were given his details.

The same two officers then went to Glenn Howard's home address nearby, arriving shortly after 8pm. On arrival, they spoke to the caretaker, who said he had not seen Glenn Howard that day but would lead them to his flat. As they were speaking, Glenn Howard was seen at the bottom of the corridor and pointed out to the police officers by the caretaker.

On the police officers' accounts, they approached Howard. When asked, Glenn Howard confirmed that he should be in hospital but asked if he could take the police officers' pulses before leaving. An officer allowed him to do this and Howard then accompanied the police officers to the exit, walking without their assistance.

At this point the officers claim that Glenn Howard tried to "give them the slip" and that a struggle then ensued just outside the common entrance to the flats. In the course of the struggle, the police officers say that one of them fell to the ground with Glenn Howard. The officers then describe attempting to restrain him whilst he was on the floor, kicking out with both his feet. They then say they handcuffed his hands in front of his body.

On the police account, other officers arrived and restrained his legs. His handcuffs were removed and Glenn Howard was then handcuffed with his arms at the back. By then, he was lying on his front. One of the officers says that she then noticed Glenn Howard had been sick. He was rolled onto his side and carried to the van by five officers (one per limb and another supporting his head).

Once in the van, the police officers say he was placed in a sitting position and taken to Sutton Police Station, a journey of about two minutes. The police say that when the van arrived at the police station, it was noticed that Glenn Howard's mouth was open and his head was "lolling back". Glenn Howard was then immediately taken to hospital, without being taken out of the police van.

It is unclear from the Police Service account of the events precisely when Glenn Howard's condition changed from struggling with officers outside the flats to his mouth being open and his head lolling back. It is also unclear how many officers were in the back of the van with Glenn Howard during the trip to the police station and then on to the hospital, and whether he was under any restraint at any time while he was in the back of the police van.

On arrival at the hospital, medical staff were of the view that Glenn Howard had not been breathing for ten minutes. The police officers told medical staff that he had had a cardiac

arrest. Glenn Howard never regained consciousness but was placed on a ventilator, where he "survived" until 1 January 1999.

Following the events of 10 December 1997, an internal inquiry was set up by the Metropolitan Police Service, under the supervision of the PCA. An outside police force has never investigated the circumstances of Glenn Howard's detention and, according to the family's lawyer, the investigation was deeply unsatisfactory. The original investigating officer had to be replaced midway through the inquiry. The PCA expressed its concerns about the police investigation in a letter to Glenn Howard's brother, Barry Howard, in December 1998. The police investigation into this matter was, therefore, extremely prolonged with a Certificate of Satisfaction not being issued by the PCA until 14 October 1999. The CPS made a decision on the same day, 14 October 1999, that there was not sufficient evidence, at that time, for any officer to be charged with a criminal offence.

The solicitor for the Howard family asked the Lord Chancellor to use his reserve statutory powers to grant legal aid for the family to be represented at the inquest into Glenn Howard's death, and the Lord Chancellor agreed to it. The inquest began on 15 May 2000.

2.2. Roger Sylvester

On the night of Monday 11 January 1999, Roger Sylvester, a black man aged 30**,** was outside his own home, in Tottenham, North London, allegedly knocking on the door.

According to police accounts, at 9.44pm, two police officers from Tottenham Police Station, alerted by a 999 call received at 9.37pm, arrived at Roger Sylvester's home. According to the 999 caller, Sylvester was acting "very strangely". The police officers stated they found him violently banging on his front door with both hands, making loud noises which they could not understand and that he continually dived to the floor without warning, beating his legs and arms on the ground and shouting. The original officers at the scene called for assistance and within minutes a total of eight police officers had brought Roger Sylvester to the ground, handcuffed and restrained him "for his own safety and that of others".

After notifying the Local Area Health Authority, in accordance with a local agreement, the police officers took Roger Sylvester in a police van to St Ann's Hospital, having purportedly detained him under Section 136 of the Mental Health Act 1983. As the police later admitted to the family, Roger Sylvester was taken away naked, even though his clothes had been recovered from outside his house. The Sylvester family's lawyer said the police admitted also that, during the journey from outside his home to St. Ann's Hospital, Roger Sylvester was restrained by at least four officers, possibly more, and that his hands were handcuffed in front of his body throughout. According to the Detective Superintendent initially in charge of the police investigation, who gave a brief statement at the inquest which opened and adjourned at St Pancras Coroner's Court on 26 January 1999, once at St. Ann's Hospital Roger Sylvester was seen by a doctor, who left the room to obtain medication. Whilst the doctor was away from the room the police officers continued to restrain Roger Sylvester who suddenly, according to police statements, went limp and collapsed. This was at approximately 10.26pm. The officers tried to resuscitate him, with the assistance of medical staff. The family's lawyer claims that, throughout this time, he was naked and that he was being restrained in the "Sec. 136 room" at St. Ann's Hospital, either on the floor or on a thin

mattress, until he became unconscious. After resuscitation attempts failed to restore his breathing, Roger Sylvester was moved to North Middlesex Hospital. As there was no intensive care unit at that hospital, he was then moved on to Whittington Hospital, where he was hooked up to a ventilator. After brain stem tests, one week later, Roger Sylvester was declared clinically dead.

Relatives and friends describe Roger Sylvester as a fit and healthy young man, stable and family-orientated. Yet, soon after his death, Roger Sylvester's family had to fight against the misrepresentation of his image by the police and the media, portraying him as a mentally ill person and a drug user. Roger Sylvester had a depressive illness - he was not schizophrenic or suffering from a severe personality disorder. Further, there is no evidence that drug abuse had anything to do with the cause of Roger Sylvester's death. Roger Sylvester's parents were particularly concerned by the statements of the first pathologist acting on behalf of the Coroner, who gave an "off-the-cuff" briefing to journalists after he had given brief evidence to the Coroner's Court on 26 January 1999. He spoke of a record of recent drug abuse, allegedly basing his remarks on confidential medical records at the hospital. However, the Sylvester family's lawyer, after making detailed enquiries, stated that the particular entry referring to recent drug abuse was "erroneous". Moreover, confidential information such as this should not have been disclosed to journalists. That pathologist has now been replaced by the Coroner and a complaint regarding his conduct is currently before the General Medical Council.

Allegations of Roger Sylvester's depressive illness being relevant to his detention or his death were rejected by his family, who confirmed that he had suffered from depression for several years but that his health had greatly improved. Moreover, his depression was related to a specific incident dating back to 1986, when he was the victim of an unprovoked attack at a festival, which left him with a facial scar from his ear to his chin. He had been very well from September 1997 onwards and, for the last five years of his life, was employed as an administrative assistant by the London Borough of Islington.

On 27 April 1999 the Metropolitan Police Service issued an apology to Roger Sylvester's family for having stated, in a press release issued on 14 January 1999, that he had been behaving in an "aggressive and vociferous manner" according to the 999 caller. This was not true. The police had previously maintained that the 999 caller on the night of 11 January 1999 had described Roger Sylvester as behaving in an "aggressive and vociferous" manner, whereas that caller had simply described Roger Sylvester as acting "strangely".

After Roger Sylvester's death, Scotland Yard set up an internal inquiry and assigned it, initially, to a Detective Superintendent at the Criminal Investigation Bureau of the Metropolitan Police Service. However an outside police force was later appointed to conduct the inquiry, led by the Assistant Chief Constable of Essex Constabulary. The investigation was conducted under the supervision of the PCA.

The eight Metropolitan Police officers involved in Roger Sylvester's death were moved to non-operational duties, pending the police investigation.

The post-mortem examinations have not been able to establish, on their own, the cause of Roger Sylvester's death. The police said they had not used either batons or CS spray and that Roger Sylvester was never "arrested". At the opening of the inquest on 26 January

1999, the Coroner heard from the original pathologist appointed by the Coroner that Roger Sylvester had marks round his wrists, because he had resisted being handcuffed, and also had various "mainly" superficial injuries to his head, arms, body and legs. These were due, according to the pathologist, to Roger Sylvester falling naked on concrete and grass surfaces, but they had not contributed directly to his death.

On 14 October 1999, the final completed report of Essex Constabulary relating to Roger Sylvester's death was received by the PCA, for the PCA to consider whether the investigation had been conducted satisfactorily. On 21 October 1999, the PCA certified that the circumstances relating to the death of Roger Sylvester had been investigated to its satisfaction. Thereafter, at the beginning of November 1999, the Essex Constabulary report was sent on to the CPS for it to consider whether charges could be brought against any of the officers involved. A decision by the CPS is pending.

Aware of the many cases in which the CPS decided not to bring charges against the police, Roger Sylvester's family is now asking for an independent inquiry, with full statutory powers. The relatives seek disclosure of all documents, and, in the interim, the suspension of the officers involved. They have also asked for a copy of the report of the pathologist instructed by Essex Constabulary, which would help the family pathologist to prepare a more informed supplementary report to provide to the CPS. This request was initially refused, due to an apparent legal argument as to who "owned" the report prepared by the pathologist and a dispute about the precise terms of a Home Office Circular issued in April 1999, which is supposed to improve pre-inquest disclosure to families of those who die in police custody. However, at the end of December 1999 the pathologist on behalf of the family (but still not the Sylvesters themselves nor their lawyer) was allowed access to the report of the pathologist instructed by Essex Constabulary.

2.3. Harry Stanley

On 22 September 1999 Harry Stanley, 46 years old, a Scottish decorator, father of three children, who was still recovering from a cancer operation sustained earlier in the month, entered a pub near his home, in Hackney, East London, for a rest. Another customer, hearing his accent and mistaking it for an Irish accent, noticed he was carrying something long in a bag and rang the police as Harry Stanley left the pub, to say that a man with an Irish accent was leaving the pub with a sawn-off shotgun in a plastic bag. In a few minutes an SO19 (armed response unit) arrived in the area. According to a Metropolitan Police statement, the two SO19 officers approached Harry Stanley from behind. A spokesperson claimed the policemen believed they were under an immediate threat from the man. It is claimed that they shouted "Stop, Armed Police!". Harry Stanley had no reason to imagine that the police were shouting at him and, according to police accounts, did not stop at that command. The police maintain that they shouted again, to which Harry Stanley responded by turning round. The police officers shot him dead, with one shot hitting him in his head and another hitting him in the left hand. In the bag, Harry Stanley was carrying a two-foot table leg which he had collected from his brother after it had been repaired.

Even though Harry Stanley had various documents on him, including his passport, his bankbook and his birth certificate, and even though the shooting occurred only about one

hundred yards from his home, his widow was not informed for more than 18 hours after her husband's death. This prevented the family from being able to arrange for their legal and/or medical representatives to be present when the first post-mortem examination was carried out on 23 September 1999, the morning after the shooting. According to police statements, police officers went to five incorrect addresses looking for relatives.

The investigation into Harry Stanley's death is being carried out by Surrey Constabulary, an outside police force, under the supervision of the PCA. However, when the family's lawyer asked if the investigation would involve any police officer implicated in the mistaken shooting by Surrey police officers of a civilian in Dorking, Surrey, it was admitted that the investigation was being advised by the firearms inspector responsible for the same officers involved in that shooting. As a result, that adviser was replaced. The final report by Surrey Constabulary, which is expected to be completed in April 2000, will be covered by public interest immunity and, even in the long term, may never be released to the family.

The officers involved have not been suspended from full duty, but have been prevented from using firearms and placed on "desk duties". An inquest was opened and adjourned. The investigating officer from Surrey stated that Harry Stanley had been challenged twice, before shots were fired.

The PCA stated that, after Surrey Police has completed its investigation of the shooting of Harry Stanley, a separate investigation will take place into the way in which the identification of Harry Stanley was handled by the Metropolitan Police and Surrey Police. This separate investigation will be carried out by Suffolk Police.

2.4. Other cases

In the following cases, Amnesty International has received less information or, as in the case of Christopher Alder, the case is pending before the courts. However, they are cases in which developments are being closely monitored.

On 1 April 1998 **Christopher Alder**, a black 37-year-old ex-paratrooper, father of two children, died in police custody in Queens Gardens Police Station, Hull, following his arrest in connection with a fight outside a night-club. The circumstances of his death remain disputed.

During the police investigation, supervised by the PCA, five Humberside police officers were suspended from duty. After examining the PCA investigation report, the Crown Prosecution Service (CPS) announced, in July 1999, that charges for misconduct in a public office would be brought against the five officers involved, for willfully having failed to take reasonable and proper care of an arrested person while in police custody. The case will reportedly be heard after the inquest into Christopher Alder's death, which is due in July 2000. Given that the case is sub-judice, this report does not give any further details.

Sarah Thomas, a 34-year-old black architectural design student at Middlesex University, died after being in a two-day coma following her arrest, in front of her house in Finsbury Park, London, in the early hours of Wednesday 4 August 1999. The arrest was carried out by two plainclothes police officers from Stoke Newington Police Station. The circumstances surrounding her death are still disputed and cannot be made public. The

investigation is being carried out by the Metropolitan Police's Complaints Investigation Bureau, because the PCA, which is supervising it, did not consider it necessary to appoint an outside force. Amnesty International is concerned that this may constitute a prejudgment of the case by the PCA.

On 16 January 2000, **Asif Dad**, a 26-year-old Asian man, died in Chelmsford, Essex, a few minutes after having been restrained by police officers. Around midnight, the police had been alerted by a 999 call about some noises in the street. Asif Dad was allegedly detained and handcuffed. He collapsed some minutes later and was taken by ambulance to Broomfield Hospital, where doctors pronounced him dead shortly after arrival. The case was referred to the PCA for supervision and an inquest was opened and adjourned. The post-mortem examination, carried out by pathologists representing the family, the police and the PCA, proved inconclusive. According to the PCA, it is not yet clear what happened and how many officers were involved. The PCA appointed the Metropolitan Police Service to investigate the case.

3. The system of investigation and prosecution of deaths in custody

The present system of investigation of deaths in custody consists of three stages: police investigation, criminal proceedings and/or inquest. Only the first one takes place in all cases, whereas the second and third ones depend on the outcome of the investigation.

3.1. Investigation

There are two types of police investigation of a death in custody in England and Wales: supervised by the PCA or unsupervised.

Unsupervised investigations are carried out by an investigating officer appointed by the chief officer of the force involved, who can choose an officer of the same force, as happens in the vast majority of cases, or an officer from an outside force.

Referral of cases of deaths in custody to the PCA by the chief officer of the police force involved is not mandatory. The PCA can be brought in by the victim's family, but relatives rarely make a formal complaint to the PCA in the immediate aftermath of the event (they may not be aware of their right to lodge a complaint and, understandably, they are trying to come to terms with what happened). In the last few years, chief officers have increasingly chosen to refer cases of death in custody to the PCA voluntarily, using the discretion they have under the Police and Criminal Evidence Act 1984 (PACE), when it appears that a police officer may have committed a criminal or disciplinary offence.

In supervised investigations, the PCA must approve the appointment of the investigating officer and can call one in from an outside force, but the PCA uses this option sparingly, reportedly because there is a lack of senior police officers willing to conduct these investigations. The PCA must then appoint one of its members to supervise the work of the investigating officer. This implies consultations between the two to agree on a plan of investigation and on general lines of inquiry and to ensure that evidence has been preserved and witnesses and suspects identified. The daily conduct of the investigation is then left to the

investigating officer, who also drafts the final report. The final report is then submitted to the PCA, to determine whether or not the investigation was satisfactorily completed.

It is then in the discretion of the chief officer of the police force which is under investigation to decide if the final report should be forwarded to the Crown Prosecution Service (CPS), which has to determine whether to bring criminal charges against the officers involved. Although in practice chief officers send almost all final reports to the CPS, and therefore their discretionary power not to send a final report of an investigation of a death in custody case may seem only theoretical, practising lawyers note that chief officers do retain that discretionary power and may use it (one of the lawyers contacted by this organization could in fact recall one case in which a chief officer did not send a final report to the CPS, although the case warranted it).

3.2. Criminal proceedings

In line with the recommendations of Judge Gerald Butler QC in his "Inquiry into Crown Prosecution Service decision-making in relation to deaths in custody and related matters", published in August 1999[7], all cases of death in custody in England and Wales should now be dealt with by Central Casework, the CPS Area which deals with cases of the most serious kind.

Judge Butler recommended that the decision as to whether or not to prosecute in a death in custody case should be made by the Assistant Chief Crown Prosecutor (ACCP), after reading and considering the whole of the relevant documentation. The ACCP should render his/her decision in a standardised and structured form, with the reasons for it. In particular cases, it may be thought appropriate that the decision is taken by the Chief Crown Prosecutor or even by the Director of Public Prosecutions (DPP). If the decision is made by the ACCP not to prosecute, the case should be sent for advice to Senior Treasury Counsel (STC), unless it is beyond reasonable doubt that there is no realistic prospect of conviction. If STC agrees that there should be no prosecution, then no prosecution should follow, but if STC advises that there should be a prosecution, the case goes back to ACCP for re-consideration. If ACCP insists on not prosecuting, the case has to be fully re-considered at Chief Crown Prosecutor level, or above. Again according to Judge Butler, if such an exceptional case arises, the DPP would wish to be fully involved, but it must be absolutely clear who has made the decision. In order for the CPS to decide to prosecute, a case must pass two tests. The first, the evidential test, requires that the available evidence provides a realistic prospect of conviction, i.e. that a jury or a bench of magistrates, properly directed in accordance with the law, is more likely than not to convict the defendant. The second, the public interest test, requires that a

[7] The Butler Inquiry was set up after the July 1997 judicial review ruling by Lord Justice Rose that overturned the Director of Public Prosecutions' decisions not to bring criminal charges against the police officers involved in the deaths of Richard O'Brien and Shiji Lapite and in the torture of Derek Treadaway. The judicial review hearing exposed the systemic flaws in the way the CPS was dealing with criminal allegations against police officers involved in death in custody cases.

prosecution be brought in cases of any seriousness, unless there are public interest factors tending against prosecution, which clearly outweigh those tending in favour.

To take its decision on prosecution, the CPS bases its considerations on the report of the investigating officer. In so doing, the CPS should review the quality of the evidence it is provided with, and, if necessary, can request the investigating officer to follow a different line of inquiry or to look for further evidence (under the Code for Crown Prosecutors).

If the CPS considers that the evidence gathered during the inquiry is sufficient to guarantee a realistic prospect of conviction and that the public interest requires prosecution, a criminal trial will begin. It should be noted that Judge Butler stated in his Report that in cases of death in police custody it is difficult to imagine circumstances in which it would not be in the public interest to prosecute.

3.3. Inquest

Soon after a death in custody occurs in England and Wales, a coroner's inquest is opened and immediately adjourned, pending the CPS decision on prosecution. Once the CPS decides not to bring criminal charges, the inquest resumes.

At the inquest the family of the victim does not have access to all the available evidence, notwithstanding the April 1999 Home Office guidance to the police on pre-inquest disclosure, advising that there should be compelling reasons why certain documents may not be disclosed to the family of the victim and their legal representatives. In fact, statements taken by the police and other documentary material produced by the police during the investigation of a death in custody remain the property of the police force commissioning the investigation and the coroner has no power to order the disclosure of any such material, without the consent of the police force involved. However, the guidance also states that all the material which is supplied to the coroner should normally be made available to all those whom the coroner considers to be interested persons. The guidance also stipulates that the instances in which they may be denied disclosure, because of the impact it might have on possible subsequent proceedings, should be regarded as exceptional and arising only where there was a genuine risk, not simply a remote possibility, that disclosure would have a prejudicial effect. According to the guidance, the investigating officer's report will not normally be expected to form part of the pre-inquest disclosure and if the chief officer decides to disclose it, expressions of opinion by the investigating officer and his/her final recommendations and conclusions should be removed. The guidance advises that disclosure be not later than 28 days before the inquest hearing.

At the inquest stage, the family of the victim is not provided with legal aid, whereas the state and the institutions involved - and thus the police officers concerned - are legally represented at public expense.

The inquest is based on the investigating officer's report. The selection and the questioning of witnesses is carried out on the basis of the report with which the coroner is presented. The choice of witnesses to testify at the inquest is at the total discretion of the coroner.

The coroner sits with a jury, which (s)he instructs on the possible verdicts. The jury cannot add riders (for example, reservations or recommendations) to the verdict and cannot

comment on the evidence, which is summed up by the coroner alone. The verdict cannot mention any individual as responsible for the death, but can state that an unlawful killing occurred, if the jury is satisfied beyond reasonable doubt and according to the criminal law standard of proof, that the death amounted to murder or manslaughter. Other verdicts include: lawful killing and open (meaning that the jury was unable to establish the cause of death).

If the jury returns a verdict of unlawful killing, the coroner sends the case back to the CPS for further consideration on bringing criminal charges.

4. Amnesty International's concerns

4.1. regarding the right to life

The Criminal Law Act 1967 provides that "*a person may use such force as is reasonable in the circumstances in the prevention of crime or in effecting or assisting in the lawful arrest of offenders or of suspected offenders or of persons unlawfully at large*".

This is in contrast to Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, which states that everybody's right to life shall be protected by law and specifies the circumstances in which the deprivation of life shall not be regarded as inflicted in contravention of the Convention. For an act of deprivation of life to be carried out lawfully, it must result from the use of force which is no more than absolutely necessary in defence of any person from unlawful violence, or in order to effect a lawful arrest or to prevent the escape of a lawfully detained person, or in action lawfully taken for the purpose of quelling a riot or insurrection.

The European Court of Human Rights interpreted the right to life not merely as the right to full protection by law enforcement officers, but also as the right to a full investigation into the circumstances of a killing by law enforcement officers, to ensure it occurred in connection with the specific circumstances spelled out by Article 2 of the Convention. In its judgment in *McCann and Others v. UK* (the Gibraltar Three case), the European Court stated: "*A general legal prohibition of arbitrary killing by the agents of the State would be ineffective, in practice, if there existed no procedure for reviewing the lawfulness of the use of lethal force by State authorities. The obligation to protect the right to life under this provision ... requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force by, inter alios, agents of the State*".

Also the United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials requires governments and law enforcement agencies to ensure that an effective review process is available, that independent administrative and prosecutorial authorities exercise jurisdiction in appropriate circumstances and that persons affected by the use of force and firearms or their legal representatives have access to an independent process, including a judicial process.

4.2. regarding the investigation procedure

The present system of investigation of deaths in custody in England and Wales, based on police officers investigating the alleged crimes of other police officers and then reporting what they discretionally consider to be the result of the inquiry to the Crown Prosecution Service, has repeatedly proved unsuitable to guarantee thoroughness and independence of investigation and accountability and transparency of decision-making, even when the police inquiry is conducted under the supervision of the PCA.

Indeed, several aspects of an investigation into a death in custody raise concerns:

- firstly, the role of the chief officer -i.e. the hierarchical superior- of the police force to which the officers under investigation belong. This chief officer appoints the investigating officer. The chief officer can choose the investigating officer from the same force, i.e. a colleague of the officers under investigation. It is again the chief officer of the force under investigation who has to decide, on the basis of the report of the investigating officer, whether there are grounds for criminal or disciplinary proceedings against his own officers. And it is still the chief officer who decides whether to refer a death in custody case to the PCA, since such referral is not mandatory;
- secondly, the role of the PCA. In fact, even if referral takes place, the PCA, according to the experience of lawyers, non-governmental organizations, and relatives of the victims, is cautious in using its powers, such as calling in an outside force to carry out the investigation, and PCA supervising officers are not perceived to take a very active approach. Concerns are raised also by the fact that the PCA does not have a code of practice, and is thus not accountable. It is not possible to know the reasons for the decision of whether or not to approve the appointment of an investigating officer, to call in an outside force, and finally to approve an investigation. According to practising lawyers, the PCA very rarely exercises its power not to approve an investigation;
- thirdly, concerns are raised by the way in which post-mortem examinations are carried out. They are obviously an essential source of evidence in deaths in custody cases, and should therefore be as thorough as possible. Yet, pathologists are not always given access to all the available evidence. They should be provided with not just the body of the victim, but also a full description of the scene of the crime and its circumstances, to allow them to assess the interrelations among all these elements and to determine not only the immediate cause of death (i.e. the medical cause of death) but also the underlying cause of death (i.e. the "real" explanation of a death). Furthermore, x-rays, which can reveal essential details, are not always available and carried out, as they are regarded as best practice.

Amnesty International's concerns about the lack of independence and thoroughness in investigations of deaths in custody are supported by the findings of various national and international authorities, which have examined this issue in recent years:

· on 16 December 1997 the Home Affairs Select Committee published its First Report on Police Disciplinary and Complaints Procedures, in which it analysed the effectiveness of the current system and the need for independence. After hearing evidence from various interested parties, such as professional associations, non-governmental organizations and lawyers, the Committee concluded that present procedures are "*inadequate both to ensure effective management and to command public confidence*", that they need to be tackled "*robustly*", and that "*independent investigation would be desirable in principle, not least because of the boost this*

would give to public confidence in the system". The Home Affairs Select Committee also recommended that the Home Office conduct a detailed feasibility study of different possible arrangements for an independent complaints investigation process, on the assumption that "*if the present system, as reformed, continues to enjoy only low credibility, then independent investigation will have to be considered*". The Home Secretary agreed to arrange for the study to be carried out and commissioned KPMG (business consultants), whose findings were made public by the Home Office on 17 May 2000. This report will be subjected to a consultation stage, to allow interested parties to comment on the findings of the study;

- the Stephen Lawrence Inquiry's Report, published in February 1999[8], recommended, inter alia, 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*" (recommendation 58);

- in August 1999 Judge Gerald Butler's Report on "Inquiry into Crown Prosecution Service decision-making in relation to deaths in custody and related matters" was published. Judge Butler regarded the procedure laid down in the Police and Criminal Evidence Act 1984, under which it is the police who investigate and report to the CPS on a death in police custody, as not being part of his inquiry. Thus, he did not make a recommendation on the matter. However, in the Postscript to the report, Judge Butler stated that he regarded it in principle as a "*questionable procedure*"and added that he was not alone in feeling uneasy about it and that he regarded the issue to be of such importance that he felt he ought to mention it "*so that those in a position to do so might give it their consideration*";

[8]The racist killing of Stephen Lawrence in 1993 and the subsequent failure by the police to carry out an independent and thorough investigation into the killing led to the establishment of a judicial inquiry which sat from July 1997 to February 1999.

- in 1998, concerns about the system of investigation of deaths in custody were also expressed by an international authority, the United Nations Committee against Torture (CAT), which noted "*the number of deaths in police custody and the apparent failure of the State party [the United Kingdom] to provide an effective investigative mechanism to deal with allegations of police and prison authorities' abuse, as required by art. 12 of the Convention [against torture], and to report publicly in a timely manner*"[9];
- more recently, strong criticism about the existing system of investigation was expressed by another international authority, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ECPT). The ECPT Report on the UK, published on 13 January 2000, noted that "*through an investigation conducted and controlled by police officers, to the moment at which a police officer is required to assess the criminal and/or disciplinary implications of that investigation, the police themselves maintain a firm grip upon the handling of complaints against them. Furthermore, the police retain a substantial degree of influence over whether criminal and/or disciplinary proceedings are brought against police officers*". Commenting on the PCA role, the ECPT stated "*in its present form the Authority appears ill-equipped to carry out the watchdog role in which it has been cast. The Authority's current functions are very tightly circumscribed and, perhaps in consequence, there is little public confidence in the PCA's independence... Consideration is being given to increasing the powers of the PCA; however the CPT is not certain that this alone will be sufficient to restore public confidence in the efficacity of police complaints and disciplinary procedures as legal remedies for police misconduct*".

4.3. regarding the decision to bring criminal proceedings

In England and Wales, the CPS decision-making process on whether to bring criminal charges against the police officers allegedly involved in a death in custody raises two major concerns:
- the decision seems to be taken on the sole basis of the report of the investigating officer, with all the limits this may have. The CPS is responsible for reviewing the quality of the evidence it is presented with in the investigating officer's report, and can ask for further evidence and for the investigating officer to follow other lines of inquiry; however, it is not clear to what extent the CPS utilizes these powers;
- the CPS**,** in applying the evidential test in cases where police officers are involved, seems to adopt a higher standard than the one it applies to bring prosecutions against ordinary citizens.

The ECPT Report notes that it has been suggested by many practising lawyers that "*Crown Prosecutors' awareness of the relatively low likelihood of securing a conviction against a police officer may tend to create a vicious circle, in which an increasingly higher*

[9]United Nations Committee against Torture, Concluding observations of the UK third periodic report, 17 November 1998.

standard of proof is required in order to justify the bringing of charges against police officers".

Lawyers specializing in death in custody cases confirm that the wish to maintain good working relations with the police can prevent the CPS from taking balanced decisions in these cases. It was submitted by a legal firm to the Home Affairs Select Committee that "*There is clearly a bias which pervades both the police and CPS preventing viable prosecutions through nonsensical analysis of evidence*".

Judge Butler in his inquiry Report took a different view on the causes of the problems in the decision-making process of the CPS in death in custody cases. His findings were that the wrong decisions in the Lapite, O'Brien and Treadaway cases had been essentially due to inefficiency and unsoundness of the working system in the CPS, and not to unfair bias. Accordingly, his recommendations focus on organizational aspects and address the need for clarity and transparency in the chain of responsibility in the decision-making process.

4.4. regarding the inquest

This stage suffers from the same inherent limitations that flaw CPS decisions, as the coroner organizes the inquest on the basis of the police investigation report.

Amnesty International is particularly concerned about the weakness of the deceased's family's position at the inquest. The victim's family's participation is impaired by both lack of information and lack of economic resources.

· At the start of an inquest, the deceased's family may know nothing about the findings of the investigation. The Coroner's Rules do not provide for pre-inquest disclosure. Witness statements gathered during the investigation are the property of the investigating police force, which may well be the investigated police force. Access to this evidence is allowed to the victim's family only with police consent, and may be granted shortly before the hearing. This puts one party to the inquest in a position of serious disadvantage and deprives the coroner and the jury of the chance to render a balanced verdict.

Concerns about lack of disclosure to the victim's family, particularly expressed by the London-based organization "Inquest", led the Home Affairs Select Committee Inquiry into Police and Discipline to state that investigation files relating to death in custody cases should generally be made available to the deceased's family before inquests and led Judge Macpherson in the Lawrence Inquiry's Report to recommend that a Freedom of Information Act should apply to all areas of policing, subject only to the "substantial harm" test for withholding disclosure (rec. 9); that investigating officers' reports resulting from public complaints should not attract Public Interest Immunity as a class (rec. 10); and, more specifically in case of death, that there should be advance disclosure of evidence and documents as of right to parties who have leave from a Coroner to appear at an inquest (rec. 42).

The Home Office responded in April 1999 with the above-mentioned circular no. 20

containing guidance to the police on pre-inquest disclosure[10], which put forward a presumption in favour of openness and advised chief officers to consider whether there were compelling reasons why certain documents may not be disclosed. However, being voluntary, the guidance may be interpreted discretionally and differently by different forces. Furthermore, as already noted, the statements taken by the police, which may come from crucial witnesses, and documentary material produced by the police during the investigation remain the property of the police force commissioning it, and their disclosure takes place only on a voluntary basis.

- The victim's family is not provided with legal aid. Whereas the police service is always represented at public expense, the deceased's family, in order to be represented, has to pay for its own lawyer, and in order to make its participation meaningful and worthwhile, has often to pay also for its own pathologist or other medical experts to challenge the evidence presented. If one considers that deaths in custody may occur in disputed circumstances, the inequality of arms between the family of the victim and the police can mean that controversial evidence is left unchallenged and, finally, that the inquest jury has to deliver a verdict on a very partial basis, without effective input from the other party to the hearing. Concerns about the economic burden the family of the victims have to face on their own were expressed in the Stephen Lawrence Inquiry; the report recommended that consideration be given to the provision of Legal Aid to the families of victims to cover representation at an inquest in appropriate cases (rec. 43).

5. Public debate: options for consideration and reform

Amnesty International believes that the numerous deficiencies and flaws in the present system of investigation and prosecution of death in custody cases cannot continue to be addressed separately. Shortcomings affect all stages of the system and produce consequences beyond the stage in which they occur.

Amnesty International calls for a thorough and wide-ranging inquiry to be established into the system of investigation of deaths in custody in England and Wales as a whole, the terms of reference of which would cover investigation and prosecution procedures as well as related matters (e.g. legal aid for families of the victims; post-mortem examinations; legislation on the use of lethal force; etc). In that context, proper consideration should be given to the numerous proposals that, in recent years, lawyers, non-governmental organizations and national and international authorities have put forward in order to respond to the failures of the system. In relation to the investigation stage, proposals range from improving and strengthening the PCA supervisory role, to setting up a new independent body. As to prosecution, they vary from finding procedures to hold the CPS more accountable for its decisions, to substituting the CPS with a different prosecuting authority in death in custody cases. Some examples are:

[10] See above, para.3.3.

- that the PCA be authorized and funded to commission independent investigations where they felt particular expertise and skills would be required and in cases where there is reason to believe that the existing process is proving inadequate (Home Affairs Select Committee);
- that the PCA adopts a code of practice, to ensure accountability on the basis of transparent criteria (lawyers);
- that HM Inspectorate of Constabulary be given a greater role and be empowered to recruit and to use lay inspectors in order to conduct examination and inspection of Police Sevices (Lawrence Inquiry rec. 8), that they be granted full and unfettered powers and duties to inspect all parts of Police Services, including the Metropolitan Police Service (Lawrence Inquiry rec. 3), and that principles and standards similar to those of the Office for Standards in Education (OFSTED) be applied to inspections of Police Services (Lawrence Inquiry rec. 5, Home Affairs Select Committee);
- that the Association of Chief Police Officers devise Codes of Practice to govern reviews of investigation of crime, to ensure that such reviews are open and thorough. Consideration should be given to such practice providing for reviews to be carried out by an external police service;
- that an independent body be set up, by a transfer of funds from police complaints budgets, to investigate only the serious cases, such as deaths in custody. There could be a pilot project, based on one region, as an initial step (Liberty to the Home Affairs Select Committee);
- that a fully-fledged independent agency be created to investigate complaints against the police, with the power to direct that disciplinary proceedings be instigated against police officers and possibly with the power to remit a case directly to the CPS for consideration of whether to bring criminal proceedings (ECPT, "Inquest");
- that independent investigations are not enough; the key test is transparency, to enable complainants to see how their complaints move from the investigation process (including the disclosure of the investigation report) to the criminal and disciplinary proceedings; and that the complainant should be given full reasons for decisions, both criminal and disciplinary (practising lawyers);
- that the CPS be required to give detailed reasons in cases where it is decided that no criminal proceedings should be brought against police officers (ECPT Report and Butler Report);
- that responsibility for prosecuting police officers be removed from the CPS "so that cases of fundamental constitutional importance are not swept under the carpet in the interests of maintaining good working relations with the police" and that a special prosecutor be appointed to consider and prosecute cases against police officers allegedly involved in deaths in custody (practising lawyers).

The inquiry should also examine the different pre-trial criminal procedures applied to police officers, as compared with members of the public, when alleged to have committed criminal offences when they claim to have been legitimately exercising their law enforcement duties. Such allegations (of assault, false imprisonment or conspiracy to pervert the course of justice for example) are recorded as complaints and investigated and subject to charge under

Part IV of the Police Act 1996. Members of the public accused of the same substantive offence, in contrast, will be investigated and charged under the Police and Criminal Evidence Act 1984. The very language which is used, requiring persons "to complain of misconduct", instead of "to report a crime", implies a privileged position for police officers which places them in a privileged position in the criminal justice process compared with the general public.[11]

6. Conclusion

The United Kingdom is obligated, under international law treaties, to guarantee the right to life and to investigate fully, thoroughly and impartially any loss of life due to actions by law enforcement officials. Existing legislation and practice have failed to meet international human rights standards. Therefore Amnesty International urges the government to institute a wide-ranging inquiry into all aspects of investigating a death in custody, whose recommendations should ensure:

1) that independent, impartial and prompt investigations are carried out into these deaths in custody;

2) that perpetrators of unlawful killings are brought to justice;

3) that legislation governing the permissible use of lethal force is in conformity with international standards;

4) a revision of police restraint techniques, in order to outlaw those involving a significant risk for life; and repeated training schemes for police officers dealing with persons in custody;

5) much greater openness in the process and easier access for victims' families to relevant documents and available evidence, during criminal investigations and in preparation for inquests;

6) the provision of full legal aid to families, which should cover lawyers' and pathologists' bills and any other necessary costs in relation to an inquest.

[11] Graham Smith, "The Butler Report: an opportunity missed", *New Law Journal*, 1999.