Toward a Lethal Force Monitor
Contents

Glossary 3
Executive Summary 4
Background 6
Socio-legal Context for Case Studies 8
Country Cases 9
Kenya 10
South Africa 24
An Agenda for the Future 36

IN MEMORIAM

Prof. Christof Heyns (1959-2021)

In drafting this report the authors benefited greatly from the insights and support of Prof. Heyns. As UN Special Rapporteur on extrajudicial, summary or arbitrary executions (2010-2016) and subsequently as a member of the UN Human Rights Committee (2017-2020) he had frequently made calls for greater attention to be given to the availability of accurate data about police use of force, and particularly about the importance of effective investigations into deaths following police contact. He spoke passionately of these themes during the launch of the first report of this project, Police Lethal Force and Accountability, in February 2021. It was with tremendous sadness that, only the following month, we mourned his sudden and untimely death following a heart attack.

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Toward a Lethal Force Monitor 3

Glossary

APCOF African Policing Civilian Oversight Forum
APS Administration Police Service
BPDLP Basic Police Development Learning Programme
DIG Deputy Inspector-General
DCI Directorate of Criminal Investigations
IAU Internal Affairs Unit
ICD Independent Complaints Directorate
IG Inspector General
IMLU Independent Medico-Legal Unit
IPID Independent Police Investigative Directorate
ISS Institute for Security Studies
IPOA Independent Policing Oversight Authority
KPS Kenya Police Service
NPS National Police Service
NPSC National Police Service Commission
SAPS South African Police Service
Executive Summary

From the US to Hong Kong, from Nigeria to France, in the last year the use of force by the police has been a topic of substantial controversy.

International standards and principles, most notably the UN Code of Conduct for Law Enforcement Officials and the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials, seek to establish frameworks for controlling state agents’ resort to force and ensuring that states establish appropriate accountability measures. In particular, these provisions task governments to effectively report incidents of force, especially when they result in death. How such standards and principles inform state practices in recording and reporting fatalities, and how those processes subsequently affect the use of force, are matters of considerable concern.

In early 2021, some of the authors of this report launched a previous one titled Police Lethal Force and Accountability: Monitoring Deaths in Western Europe. It assessed state processes for recording deaths resulting from or connected with law enforcement activities, as well as the availability and reliability of information regarding such deaths, in four jurisdictions: Belgium, England and Wales, France and the Netherlands. The report concluded that the existing procedures and policies for recording, investigating and disclosing information on deaths associated with the application of force by law enforcement officers in these jurisdictions is wanting. While elements of good practice exist, the procedures and policies are often lacking in critical respects, including in relation to their scope, accuracy, accessibility and lesson-learning. As a result, Police Lethal Force and Accountability contended that police across all four jurisdictions need to enhance their data collection, data analysis and public communication activities.

Toward a Lethal Force Monitor extends this earlier report in two ways. First, in respect of scope, it applies the accountability criteria established in relation to the above Western European jurisdictions to two countries in Africa: Kenya and South Africa. Those criteria pertain to:

- The availability of official statistics on the extent of fatalities associated with uses of force by law enforcement officials;
- The procedures for collecting and publishing official data;
- The quality of such official data;
- How lessons are or are not learnt from the analysis of deaths;
- The characteristics of investigations by official agencies.

As elaborated in the country analyses that follow, while policing agencies in both Kenya and South Africa are overseen by authorities that strive to be an effective check against police impunity, in both countries concerns can be raised about the public awareness of, access to, and confidence in the information collected on the use of lethal force. Relatedly, evidence that law enforcement agencies analyse information about the use of force in order to identify learning opportunities, or act to revise their policies and practices in light of lessons learnt, is either missing or scant.

In addition, while the Independent Policing Oversight Authority (IPOA) in Kenya is able to generate statistics on the use of lethal force, it does so based on complaints received and formal notifications from the National Police Service. As the majority of cases of officer-involved deaths are no longer reported to IPOA, significant ground is lost regarding the reliability of the IPOA’s statistics.1 What recommendations have been made by the IPOA into deaths caused by the police have also been largely ignored, and cooperation from the National Police Service remains a significant challenge.

In South Africa, while the Independent Police Investigative Directorate (IPID) is mandated to investigate and report on various allegations of misconduct by the South African Police Service, its ability to do so in practice is hampered by various factors. Notably, the IPID’s investigative programme is overburdened while being severely underfunded, understaffed, and lacking in certain specialised skills. Unlike IPOA, it does not have the authority to supervise investigations by an internal affairs unit, or other police investigators and thereby prioritise its investigations. Meanwhile, its independence is compromised by its reliance on the South African Police Service for expertise and dependence on the Minister of Police for budget and operational priorities.

Consequently, while Kenya and South Africa have notable police accountability mechanisms in place, both systems still have scope for improvement in making those institutional structures more robust and effective. Our country studies of Kenya and South Africa provide detailed recommendations for reform.


Recording and making publicly accessible information on the police use of force, particularly in relation to lethal force, is an important step in ensuring accountability.

In systems where democratic principles and the rule of law are accepted as the basis of good government and legitimate authority, ensuring that state agencies are restrained and answerable for their conduct in law enforcement requires that all instances of the use of force and its consequences are publicly reported. In addition, reliably documenting the incidence and circumstances surrounding deaths (and other cases where force is used) can enable law enforcement agencies to learn lessons by reviewing and revising their policies, procedures and training provisions. It can also facilitate external monitoring and scrutiny, be that from oversight bodies, civil society, the media, community groups and others. Documenting force and learning lessons are also a way of respecting those who die, responding to the needs of their families and maintaining trust in the wider community beyond those immediately affected.

In this spirit, efforts are underway within individual countries to compile and analyse data about lethal force in law enforcement.1 Not only do such efforts hope to reduce the number of times that members of the public are killed, they also hold out the promise of identifying how to reduce assaults and fatal attacks on law enforcement officers.2

However, existing knowledge of the police use of lethal force is limited in varied respects. In some countries, official data is either completely missing, highly limited or of doubtful accuracy. In France, for instance, the two national law enforcement forces (Police and Gendarmerie) are characterised by a profound lack of transparency. Very little information is provided to the public, either on cases of injuries and deaths, or on the disciplinary and judicial investigations and reviews following deaths.3 In such situations, it is vital that public authorities undertake basic steps to produce, analyse and use evidence as part of monitoring and evaluation efforts.

While in the case of France the rate of police killings per population appears comparatively low and deaths are likely to be reported through official channels (such as the news media), elsewhere the situation is different. For instance, in Mexico the scarcity of official information combined with the under-recording of deaths in the media suggests that figures on lethal force should be treated with considerable caution.4 The case of Mexico also underscores the importance of attending to a broad range of law enforcement officials5 rather than just those working in police agencies. The Mexican Army and the Navy have been involved in domestic policing activities resulting in civilian deaths, sometimes with the involvement of federal and local police. Without the inclusion of these military forces within record keeping, any understanding of the magnitude and characteristics of civilian deaths would be incomplete. This applies, to some extent, to other countries in Latin America and the Caribbean, where the war on drugs and gangs is often seen as being at the centre of violent confrontations.

Elsewhere, official information is patchy or of questionable reliability. As has recently been argued in the case of the US, despite the long-term concerns about high levels of police killings, successive state and federal governments have failed to collect reliable data, investigate the causes of high death rates, or develop administrative standards to reduce unnecessary killings.6 The US is hardly alone in being open to such charges. Although Belgium, the Netherlands and England & Wales experience fewer incidents of lethal force (on a per capita basis), the report Police Lethal Force and Accountability pointed to significant deficiencies in the manner data is collected and utilised in those jurisdictions. For each, greater thoroughness in recording and/or making publicly available information on deaths is required. Further, while each system has some processes in place for learning from past deaths and adjusting strategies and policies, the extent to which this takes place in practice is wanting in certain respects.

As a result of these and other issues, attempts to compare deaths associated with police officers or other law enforcement officials are bedevilled by difficulties, as too are attempts to learn lessons across jurisdictions. Doing so requires understanding how police use of force is defined, how information is compiled, the limits of such compilations, how information is analysed and how it is made accessible. Undertaking such work is particularly important given the emphasis that international standards and texts – including the United Nations Human Rights Guidance on Less-Lethal Weapons and Related Equipment in Law Enforcement and the report on Extra-custodial use of force by the UN Special Rapporteur on Torture and other Cruel Inhuman or Degrading Treatment or Punishment – have placed on reporting use of force, including but not limited to, cases where death has subsequently occurred. At the national level, too, some countries have moved to improve their use of force reporting (with England & Wales introducing a new system for recording all forms of force in 2017) or have further need for reporting further measures in the future (e.g. the US).

Toward a Lethal Force Monitor first assesses the availability and reliability of data about lethal force in relation to Kenya and South Africa. For the purposes of this report, lethal force refers to all deaths (whether intended or unintended) resulting from or associated with any application of force by state agents with responsibility for policing and law enforcement. This definition is taken as covering a range of situations, including but not limited to the apprehension of suspected offenders, acts of defence of self or others against perceived threats, restraint of suspects or arrestees, as well as the management of public order.

Then, on the basis of assessing the practices in those countries, this report sets out an agenda for future work to monitor the use of lethal force by law enforcement officials.

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6 As defined in the UN Code of Conduct for Law Enforcement Officials (commentary to Section 1): (a) ‘[f] officers of the law, whether appointed or elected, who exercise police powers, especially the powers of arrest or detention. (b) In countries where police powers are exercised by military authorities, whether uniformed or not, or by State security forces, the definition of law enforcement officials shall be regarded as including officers of such services.’


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In both Kenya and South Africa, the legitimacy of the police, their use of force, and the independence or effectiveness of bodies charged with overseeing their conduct have been socially and politically charged for some time.

They are also two jurisdictions where the number of deaths following police action appear to be comparatively high — in South Africa, over the past five years, the number of deaths as a result of police action has not been fewer than 390 each year, (with at least a further 200 deaths in custody each year); estimates for Kenya are more varied, but begin at the lower estimate of a figure of 100 deaths each year.

In Kenya, the involvement of police officers in the post-election violence of 2008 was highlighted during the Waki Commission of Inquiry that followed. Thereafter a systemic overhaul was undertaken, involving the National Task Force on Police Reforms and its recommendations for a new Police Act, the position of the police within the new Constitutional dispensation and the creation of a new oversight body, IPOA.

In South Africa, the police had been institutionally reformed with the new Constitution in the mid-1990s, and an oversight body (the Independent Complaints Directorate, ICD) had been created at that time, but public distrust of a “service” that remained as brutal as the “force” it had replaced continued through the new democracy, with frequent clashes during service delivery protests and labour disputes reaching a low point in 2012 with a highly politicised tragedy at Marikana, in which more than 30 striking mine-workers were shot and killed by police. The efforts of the police service to avoid meaningful review of its decision-making process in the lead-up to that fateful event — later exposed during a Commission of Inquiry served as a reminder of the continued investigative limitations of police oversight, notwithstanding the fact that ICD had been formally reconstituted from the old ICD the previous year.

For two institutions that share a similar basic design, in a way, IPOA and IPID face opposite challenges. After a preliminary honeymoon period of relatively high levels of police self-reporting and public engagement with complaints procedures, IPOA has recently found cooperation with the National Police Service a serious challenge: without notification, they tend either to learn about cases too late to begin or to control an effective investigation, or — it seems likely — are in many cases not informed at all of relevant cases. Conversely, IPID is flooded with referrals regarding the full range of police abuses within their mandate, to the extent they are unable to dedicate sufficient resources to important investigations. This results in challenges in bringing cases to a successful conclusion, which, taken together with the perceived lack of independence resulting both from its status relative to the Minister of Police and the proportion of its investigators who have some personal history with the police, has led to diminished public trust in its ability to hold the police to account.

The two country reports that follow examine a number of issues in relation to Kenya and South Africa, including:

- Official statistics on fatalities related to uses of force by law enforcement officials;
- The procedures for collecting and publishing official data;
- The quality of such official data;
- How lessons are or are not learnt from the analysis of deaths;
- The characteristics of investigations by official agencies;
- The availability of relevant data from unofficial sources in each country.

These findings were derived from an initial comparison of the procedures, policies and practices in both jurisdictions, as well as through drawing on secondary literature about the police use of force. The authors from the University of Pretoria provided a provisional classification of those policies and practices according to the schema set out at the start of each country report. Subsequently, all of the authors of Toward a Lethal Force Monitor discussed these initial classifications and adjusted them where necessary to ensure that they were consistently calibrated relative to each other. These classifications were themselves based on reasonable, evidence-based evaluations of existing practices.

The colour coding in the tables appearing at the start of each country report represents the outcomes of the process of deliberation. In the absence of any international benchmarking standards, the classifications given are intended as indicative, headline summations of the evidence presented. The individual country reports should be consulted for specific detail about the procedures, policies and practices in each system, as well as recommendations for each jurisdiction.
Kenya

Data Collection and Publication by Official Agencies

Based on 2018-2019 reporting period:

1. Are the number of deaths following any police use of force (be it firearms, 'less lethal' weapons or other force):
   - Collected? P
   - Publicly available? P
   - Is this a legal requirement? Yes
   - Can such information be requested from the authorities via FOI laws? P
2. If published, to what extent is the number of deaths readily identifiable from official statistics?
   - What work needs to be done to pull these out? L
3. Are the deceased identified by name? L
4. Is demographic and other information for the deceased (including ethnic background, age and gender):
   - Collected? G
   - Publicly available? L
   - Is this a legal requirement? No
   - Can such information be requested from the authorities via FOI laws? G
5. Is demographic and other information for LEOs:
   - Collected? G
   - Publicly available? L
   - Is this a legal requirement? No
   - Can such information be requested from the authorities via FOI laws? G
6. Is information on the circumstances:
   - Collected? G
   - Publicly available? L
   - Is this a legal requirement? No
   - Can such information be requested from the authorities via FOI laws? G
7. Is information about the type(s) of force used:
   - Collected? G
   - Publicly available? L
   - Is this a legal requirement? No
   - Can such information be requested from the authorities via FOI laws? G

Key

G Good, Robust
P Partial, Medium
L Limited, Poor
N None
U Unknown
N None
U Unknown

Data Quality of Official Sources

8. How reliable are the sources used to produce official statistics about deaths? L
9. Internal quality assurance / verification conducted P
10. Methodology for data collection publicly specified G
11. How reliable are the overall figures produced? P

Data Analysis and Lessons Learnt

12. State / police agencies analyse data to generate evidence-based recommendations / lessons learnt, in order to prevent future deaths U
13. Evidence that state / police agencies act on the results of their analysis, including applying lessons learnt U
14. External bodies are able to reuse data for their own analyses P
15. External, non-governmental agencies collect, and are able to publish, their own statistics on deaths following police use of force G

Investigations by Official Agencies

16. Is there a legal requirement for deaths to be independently investigated? G
17. Is there an authority, separate from the one involved in the incident, which conducts investigations into deaths? If so, which organisation(s) conduct these investigations? ★
18. How independent are the investigations conducted by the organisation(s) named above? P
   - Please consider the extent to which they are independent and separate in terms of a) legal structure, b) hierarchy, c) investigative activity and personnel, d) operational ability (or ‘self-reliance’) e) oversight and control
19. Involvement of close relatives in the investigations P
20. Investigation reports into deaths are:
   - Publicly available? L
   - Do they give reasons for the conclusions they have reached? U
   - Is this a legal requirement? No
   - Can such information be requested from the authorities via FOI laws? G
21. Information available on legal proceedings against agents / officials pursuant to deaths G
22. Information available on legal proceedings against state agencies pursuant to deaths G
23. Information available on disciplinary proceedings against agents/officials pursuant to deaths L
24. Number of prosecutions against agents / officials involved in the last ten years? U
25. Number of convictions against agents / officials involved in the last ten years? U
26. Number of prosecutions against agencies involved in the last ten years? U
27. Number of convictions against agencies involved in the last ten years? U
28. How readily available is information about prosecutions and convictions? P

★ IPOA; Kenya National Commission on Human Rights.
Introduction

The National Police Service (NPS) of Kenya operates throughout Kenya, both at the national and county level. Under the Constitution of Kenya, the NPS consists of the Kenya Police Service (KPS) and the Administration Police Service (APS). The KPS and APS are each headed by a Deputy Inspector-General (DIG-KPS and DIG-APS) appointed by the President in accordance with recommendations of the National Police Service Commission (NPSC). The recommendations for appointment made by the NPSC are not subject to review or reconsideration by the President. The KPS, APS and the Directorate of Criminal Investigations (DCI) are under the overall command and control of the Inspector General of the NPS (IG-NPS) who is appointed by the President with the approval of parliament.

Under the National Police Service Act (2011), one of the functions of the IG-NPS is to organize the NPS at the national level into formations, units and components. In this regard, the KPS, NPS and DCI have various units and formations. Previously some of these units had similar functions but were operating under different commands. To streamline the operations of the NPS in order to enhance efficiency and effectiveness in service delivery, a reorganization process was initiated. In September 2018, the President launched the Policy Framework and Strategy for the Reorganization of the National Police Service. In the reorganized NPS, the DIG-KPS, the DIG-APS and the Director of Criminal Investigations have specific and distinct functions. The DIG-KPS focuses on public safety and security whereas the DIG-APS focuses on protective and border security, critical infrastructure protection and stock theft prevention. The DCI focuses on criminal investigations.

The reorganization also saw the integration of General Duty officers under both the KPS and NPS to become one under the command of the DIG-KPS. A biometric registration drive of the NPS, reported in 2019, put the number of police officers at 101,288. Against a total population of 47,564,296 people, the ratio of police officers to population is approximately 1:470.

Police officers are expected to be proficient in the use of issued arms, hence they undergo firearms training at the training schools and colleges. Subsequently officers are required to undergo regular and frequent weapon training, including annual “musketry” training. Whether or not an officer is armed and the type of weapons they may carry depends on the duties they are performing at any given time: firearms can only be carried when the nature of the duty to be performed demands. Officers on general patrol duties must have personal issue equipment and a baton.

In addition, patrol cars carry riot batons, smoke grenades, handcuffs, among other equipment. Where circumstances necessitate the issue of firearms, such police officers may be equipped with a rifle, revolver, AK47, automatic pistols and/or automatic carbines. Specialized units like the riot squads are in addition issued special arms like tear gas pistols.

When firearms are carried, they are to be secured in a holster. When in plain clothes or on special duties, the holster should be out of sight.

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Section 1: Data Collection and Publication by Official Agencies

This report covers the 2018/2019 financial year which spans from 1 July 2018 to 30 June 2019. Data on deaths following police action are collected by the Independent Policing Oversight Authority (IPOA), an independent oversight body established in 2012. The principal functions of IPOA include investigating complaints against police officers and monitoring and investigating policing operations affecting members of the public. IPOA has nine offices across the country (eight regional offices and the head office in the capital). As of December 2018, IPOA had 213 members of staff.

Section 7(1)(a) of the IPOA Act empowers IPOA to investigate any death or serious injury occurring or suspected of having occurred as a result of police action. In addition, Section 25 of the Act requires police officers to report all deaths resulting from police actions to IPOA. It is from these reports as well as complaints received from the public that IPOA collects its data. The data are published in IPOA’s annual and semi-annual performance reports, which can be accessed on its website. However, the website is not regularly updated.

From the reports, the number of deaths of which IPOA has been made or become aware can be identified with ease. This is particularly the case with the semi-annual performance reports where the Authority indicates the number of complaints received involving deaths from police action. However, the Authority classifies cases of deaths in police custody separately, without indicating the circumstances under which the deaths may have occurred. This may have an impact on the accuracy of the data since in some cases, a person may die in police custody after the use of force. For example, if excessive force is used against an arrested person and they are taken to hospital where they later die, it is not clear whether IPOA would classify such a death as a death in police custody or a death from police action.

Generally, the reports do not contain names of the deceased persons. However, where investigations and prosecutions have been completed and convictions obtained, the names are published in the reports. In relation to cases pending before Court, IPOA’s reports for the period covered in this report did not contain names of deceased persons. In more recent reports, the names have been published. Where police operations such as public order policing are monitored, the monitoring reports may identify deceased persons by name.

In every case where an investigation into a death is initiated, the demographic information of the deceased is collected by IPOA. The police also collect this information in cases where they notify IPOA about a death. Usually, the information is not available to the public. However, one can make a request under the Access to Information Act, No. 31 of 2016. Still, such a request would be subject to Section 24 (15) of the IPOA Act which provides that information concerning matters that are still under investigation remains confidential. Similarly, demographic and other information for law enforcement officials is collected by IPOA but is not publicly available. However, a request for information can be made under the Access to Information Act.

In relation to the circumstances surrounding a death and the type of force used, the information is collected by IPOA through investigations involving interviews with witnesses and forensic analysis where appropriate but is not available to the public in the initial stages. Where investigations have been completed and a criminal case has been filed, such information can be obtained from IPOA’s performance reports, though not in sufficient detail. The reports only indicate the criminal charges leveled against the accused officer, without detailing the circumstances under which the alleged offence was committed. There has also been inconsistency in the sharing of information on the type of force used. In some of its reports, IPOA presents data on ‘deaths from police action’ while in others it presents data on ‘deaths from police’ action. In the latter case, it is not possible to tell the type of force used.

With respect to longer-term trends, no official data on deaths by police action could be traced for the period prior to IPOA’s establishment.

Section 2: Data quality

The sources used to produce official statistics are unreliable. This is because IPOA generates its data from complaints received from members of the public, other state actors, non-state actors (including the media and civil society organizations) and formal notifications from the NPS about deaths from police action. In relation to notifications from the NPS, the majority of cases of officer-involved deaths are not reported to IPOA. Since IPOA’s establishment, there has been a steady decline in the number of such notifications, even though this is a legal requirement. In cases where notifications are given, this is sometimes not done sufficiently promptly to facilitate an effective investigation.

Not all the complaints IPOA receives are investigated and IPOA reports do not indicate which of the complaints received were the subject of investigation. For example, between January and June 2018, IPOA received 1,133 complaints. Of these, 78 related to deaths from police shooting while 27 concerned deaths in police custody. IPOA conducted investigations in 99 cases. The performance report for the 2018-19 period does not indicate whether all the cases involving deaths were investigated and the information received was verified. In the absence of evidence of verification, it may not be possible to conclude that all the complaints touching on deaths from police action were accurate.

In terms of internal quality assurance, IPOA investigates the cases it receives and the investigation reports are analysed by various levels of its management. To begin with, a case intake

37 For example, in the 2019 performance reports, IPOA has data on deaths from police action, with no specific details on the type of force used. On the other hand, in the January to June 2018 performance report, IPOA has data specifically on deaths from shooting.
39 For example, in 2013 IPOA received 162 notifications and in 2014 it received 92. In 2015, 2016 and 2017, the notifications reduced drastically to 24, 9 and 7 respectively. The 2018 semi-annual performance reports have no data on the number of notifications received from the NPS. For an illustration of the decline in the number of notifications, see Probert, T., Ruteere, B. & Kimaru, M. Strengthening Policing Oversight and Investigations in Kenya (n. 3 above).
41 See Sections 4 and 8 of the Access to Information Act. No. 31 of 2016. Available at: http://kenyalaw.org/fileadmin/pdfdownloads/Acts/ AccessToInformationAct623142016.pdf. The right of access to information may be limited if the disclosure of information may prejudice national security, due process of law, the health or safety of a person, among other reasons listed in Section 6 of the Access to Information Act. 
committee analyses the complaints received to determine their admissibility. Preliminary inquiries or investigations may be conducted in respect of the admitted cases. Once investigations have been completed, the investigation reports must be scrutinised by the Legal Department. It is only after the reports have been scrutinised internally that a file may either be closed or forwarded to the Office of the Director of Public Prosecutions for further action.

Overall, the data that IPOA has on deaths resulting from police action is unreliable. By law, the NPS is required to notify IPOA of any death or serious injury which are the result of police action or were caused by police officers while on duty. Though IPOA has been gradually increasing its number of offices across the country, and making efforts at public outreach, the public still has limited access to it and, for that reason as well as more general characteristics of deaths after police action, compliance by the NPS with its obligation to notify IPOA about deaths is essential. However, as stated above, the NPS rarely complies with this obligation meaning there are many deaths which IPOA does not record. In relation to deaths in police custody, the National Coroners Service Act, enacted in 2017, provides that where a death occurs in police custody such deaths should be reported to the Coroner General who should then investigate the case and share the report with IPOA. However, the Act has not been operationalized and so IPOA still relies on the police and the public for such reports. Compared to unofficial data from other sources, IPOA’s figures are significantly lower. The NPS, on the other hand, does not publish records on deaths following police action. It seems likely, therefore, that the available official data do not accurately reflect the magnitude of the problem.

In most of its performance reports, IPOA has been citing non-cooperation by the NPS as one of its biggest challenges. As earlier noted, the police have also consistently failed to notify IPOA about deaths resulting from their action, thereby impeding independent investigations. In addition, there are cases where the police interfere with the collection of evidence or intimidate witnesses. This is evidence that the NPS has not been taking concrete steps to prevent deaths in line with recommendations from IPOA and other state and non-state agencies.

There is no legal bar to external bodies using IPOA’s data for their own analysis. In addition, external and non-governmental organizations can collect and publish their own statistics on deaths by police action. For example, the Daily Nation, a privately-owned newspaper, has been running an online database in which it has been recording data on deaths from police encounters since 2015. The database draws on IPOA sources, but also tracks the demographics of each person killed by the police and the circumstances surrounding their deaths.

**Section 3: Data Analysis and Lessons Learnt**

Sections 10(1)(m) and (t) of the NPS Act requires the IG-NPS to cooperate with and implement the decisions of IPOA, and act on their recommendations. Thus, IPOA’s data and recommendations relating to death by police action should ideally prompt the NPS to put in place corrective measures. However, there was no evidence that the NPS analyses or takes into account IPOA’s data and recommendations in order to learn lessons and prevent future deaths. In fact, the NPS has mostly been challenging the accuracy of IPOA’s data.

The recommendations made by IPOA in relation to investigations into deaths by police action have also been largely ignored. For example, in respect of public order management, IPOA has in the past recommended that the IG-NPS should investigate and hold accountable the operational commanders during policing operations if officers under their command use excessive force leading to deaths and serious injuries. In relation to investigations, IPOA has called on the IG-NPS to ensure that police officers cooperate with it during investigations. That there has been no reduction in the frequency of deaths from police encounters, including during protest, is an indication that no lessons have been learnt.
Section 4: Investigations by Official Agencies

Both the NPS Act and the IPOA Act require the police to report all cases of deaths or serious injuries to IPOA for purposes of independent investigations. In addition to IPOA, the Kenya National Commission on Human Rights, a national human rights institution, may also investigate deaths, in line with its mandate to investigate cases of alleged human rights violations. If and when such investigations are conducted, they complement IPOA’s.

Following the conclusion of an investigation by IPOA, cases that disclose a criminal offence are referred to the Office of the Director of Public Prosecutions (ODPP) which may then elect to prosecute all or some of the cases, depending on its own analysis of the evidence. Information on the number of cases that are prosecuted can be obtained from IPOA’s periodic reports. The reports indicate the case numbers and the nature of offence committed in respect of cases pending before court and those that have been concluded. Judgments delivered by the High Court can also be accessed through the Kenya Law Reports website.

IPOA focuses mainly on criminal prosecution of individual officers, therefore there were no records on civil proceedings against the NPS over deaths. However, there are several cases where civil proceedings have been instituted against the NPS by victims’ families or human rights organizations. Information on some of the cases can be obtained through a random search in the Kenya Law Reports website. This is however not reliable since the website only reports cases heard in the superior courts. In addition, getting the information would involve reading through thousands of search results to determine which cases involved deaths.

In relation to information on disciplinary proceedings against officials pursuant to deaths, the NPS does not share information on such proceedings. The annual reports of the Internal Affairs Unit (IAU) have very limited information on disciplinary proceedings. For example, in the 2018 annual report, the IAU reported that 32 officers were found culpable of disciplinary and criminal offences. There was no information on the offences committed by the officers and the disciplinary action taken against them.

IPOA’s reporting on the number of prosecutions against officers is unclear. First, save for a 2019 report which has details on the nature of cases before court, all the other reports focus only on the number of cases, and this includes offenses that do not involve deaths. It is therefore not possible to know how many of those cases relate to deaths from police encounters. The January-June 2019 performance report has a list of 67 cases being prosecuted, with the list including cases from the past 10 years. From the list, it is possible to count 40 cases relating to deaths that were filed between 2013 and 2018. However, IPOA’s reports on prosecutions only have cases that are still pending before court and cases where convictions have been secured. There is no information on how many prosecutions of cases involving deaths resulted in acquittals or discharge of the accused officers. For example, in the 2016/2017 period, IPOA reported having 96 cases in court. As of December 2018, there were 40 cases. There was no explanation for the difference.

Since its establishment through to the reporting period, IPOA had secured convictions in only four cases involving deaths following police actions. This contrasts with 160 cases that have been forwarded to ODPP as of June 2019 (not all of which necessarily related to deaths). There are no records on the number of civil proceedings against the NPS agencies. Information about convictions of officers is readily available in IPOA’s periodic reports. In relation to the prosecutions, there is no clarity in the numbers reported since cases are carried over from one reporting period to another and no explanation is given for the difference in numbers. In addition, cases involving murder are heard by the High Court and once the cases have been concluded the judgment is posted on the Kenya Law Reports website which the public can access. Inquests and cases involving manslaughter are heard by subordinate courts and are not reported in the Kenya Law Reports website.

IPOA’s investigation reports are not publicly available and there is no legal requirement for them to publish the reports. On the contrary, Section 24(15) of the IPOA Act provides that “…any document or statement drafted or made or taken during an investigation shall remain confidential until the Authority in writing determines otherwise.” General information about the number of investigations conducted and the nature of cases investigated can be obtained from IPOA’s Performance Reports which are publicly accessible. Where specific information about an investigation is required by a member of the public or any agency, they may submit a request for information under the Access to Information Act. The information requested may relate to the demographic information of the officers and victims, the circumstances of a potentially unlawful killing or the findings of the investigation.

The NPS Act requires police officers to notify the relatives or friends of a deceased person whenever they report to IPOA any use of force that leads to death. As a matter of practice, IPOA usually involves the families of the deceased persons, especially in the initial stages of an investigation.
when statements are recorded and autopsies conducted. Beyond that, IPOA updates relatives on the progress and outcome of the investigations. In relation to the frequency of updates, there have been complaints about inordinate delays in updating relatives about the progress and outcome of investigations. More recently – after the reporting period of this report – IPOA have taken steps to address this, also in light of the Victim Protection Act (2014). Along with development partners, IPOA have developed a training curriculum on Victim Support, addressing not only interviewing families as victims and/or witnesses, but also issues of communication and liaison regarding the status of the investigation.

On the question of independence, IPOA has generally exhibited a high level of independence. In relation to legal independence, IPOA is an independent statutory body established under the IPOA Act, Section 4(1) of the IPOA Act guarantees its independence, stating that in the performance of its functions, the Authority shall not be subject to any person, office or authority. Section 4(4) also states that no person or body may interfere with the decision making, functioning or operations of the Authority. There have also, more recently, been proposals to enhance IPOA’s independence by entrenching it in the Constitution as an independent commission.

In terms of operational independence, IPOA has adequate powers of investigation, including the power to take over investigations being conducted by the NPS. IPOA is however heavily dependent on cooperation from the NPS in the conduct of its investigations or effective performance of its functions. The consistent failure by the NPS to notify IPOA about deaths resulting from police action has had an adverse impact on the reliability of data IPOA has on deaths resulting from police action. In addition, IPOA depends on the NPS to conduct forensic and ballistic examinations in some of the cases it investigates. In such cases, interference with evidence by the police is a possibility.

In addition to operational independence, the independence of members of staff is an important factor. Members of IPOA staff are appointed by the Board of the Authority. The Board members, on the other hand, are appointed through a process that involves a variety of stakeholders, including representatives from the Office of the President, the Kenya National Commission on Human Rights, the Judicial Service Commission, the Public Service Commission, among others. Interviews of shortlisted applicants are conducted publicly and successful candidates must be vetted by Parliament. This rigorous process, to a great extent, ensures the independence of the Board and staff of the Authority.

With respect to financial independence, Section 32(1) of the IPOA Act provides that ‘the funds of the Authority shall consist of (a) monies allocated by Parliament for the purposes of the Authority and; (b) such monies as may be lawfully granted, donated or lent to the Authority from any other source, with the approval of the Cabinet Secretary and the Cabinet Secretary for Finance.’ Section 32(2) then states that no money shall be accepted by IPOA from the NPS. Therefore, while IPOA is funded by the government, the NPS is completely separate. However, as indicated in IPOA’s reports, the oversight mandate has been adversely affected by inadequate financial and human resources.

Section 5: Non-Official Sources

The National Newsplex maintains a deadly force database that records all deaths from police actions in Kenya since 2015. National Newsplex compiles its data from local media and human rights reports, IPOA, other human rights organisations and social media. The National Newsplex database records details of each victim such as name, age, occupation and circumstances of death. The number of deaths recorded does not include suicides by police or self-inflicted deaths during police encounters or in custody.

The Independent Medico-Legal Unit (IMLU) is an NGO focused on extrajudicial killings and torture in Kenya. IMLU’s reports do not provide details of the victims but provide statistics on gender, location and broad circumstances of death (which it categorises for example as summary executions, protection of life, and unclear circumstances).

The statistics given by unofficial sources often differ significantly when compared to IPOA’s official records. For example, in 2018 while the Daily Nation’s Deadly Force Database recorded 250 deaths caused by police, IPOA recorded 89. In 2019 the Daily Nation’s Deadly Force Database recorded 122 deaths while IPOA recorded 163 deaths. Even between unofficial sources, the number still differs: in 2017 while the Daily Nation’s Deadly Force Database recorded 256 deaths, IMLU recorded 152.

86 The Independent Medico-Legal Unit (IMLU) is an NGO focused on extrajudicial killings and torture in Kenya. IMLU’s reports do not provide details of the victims but provide statistics on gender, location and broad circumstances of death (which it categorises for example as summary executions, protection of life, and unclear circumstances).

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Recommendations

Regarding the official detection and investigation of cases

• The NPS and IPOA should collaborate to consider means of strengthening notification protocols, and incentivising early and comprehensive notification by station commanders.

• IPOA should treat as a complaint any media or other report (concerning a death resulting from police action) upon which they follow-up to establish whether there is a case to investigate.

• The accurate inclusion, both for investigative and reporting purposes, of deaths potentially linked to police action would be greatly enhanced by the operationalisation of the recent Coroners Service Act. The new Coroner General, when appointed, should view this as a priority area.

• IPOA should continue its public outreach and communication efforts to ensure that potential complainants are aware of their rights, and of potential means of contacting IPOA in the event of death resulting from police action. These efforts should be particularly focussed beyond large urban centres.

Regarding the public reporting of cases

• IPOA should resume the regular publication of its Performance Reports. Those documents should report on the complaints received and the status of all the cases, including on decisions to hold preliminary or full investigation, or decisions not to investigate in such a way as to provide a full understanding of the scope of their work.

• IPOA should standardise across all its reporting whether to discuss “police shootings” or “deaths following police action”. The latter (which, of course, could be disaggregated) is more inclusive, and would be preferable.

• In addition to its Performance Reports, which of necessity address a range of issues, and which with respect to deaths will tend to focus on the progress of particular investigations, IPOA should consider the periodic but regular publication of a dedicated statistical release concerning the number of known deaths following police action during a given period. This release could and should be coordinated with other institutions that regularly receive complaints (such as the Kenya National Human Rights Commission) so that numbers can be reported accurately regardless of which body is or has been investigating the case.

Regarding the institutional/policy response to cases

• IPOA should undertake a follow-up or review exercise of recommendations it has made to NPS concerning use of force and deaths resulting from police action, and should report on the outcome in a similar fashion to the way it documents recommendations made in other context (such as with respect to custodial facilities).

• All stakeholders (IPOA, the Human Rights Commission, and civil society organisations) should consider means of increasing awareness of deaths resulting from use of force by other arms carriers (e.g. Wildlife Services) with a view to embracing a more inclusive understanding of IPOA’s mandate as including the investigation of any death resulting from contact with a law enforcement official.
### Data Collection and Publication by Official Agencies

Based on 2018/19 reporting period:

<table>
<thead>
<tr>
<th>Question</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are the number of deaths following any police use of force (be it firearms, ‘less lethal’ weapons or other force):</td>
<td>Collected?</td>
</tr>
<tr>
<td>2. If published, to what extent is the number of deaths readily identifiable from official statistics?</td>
<td>G</td>
</tr>
<tr>
<td>3. Are the deceased identified by name?</td>
<td>L</td>
</tr>
<tr>
<td>4. Is demographic and other information for the deceased (including ethnic background, age and gender):</td>
<td>Collected?</td>
</tr>
<tr>
<td>5. Is demographic and other information for LEOs:</td>
<td>Collected?</td>
</tr>
<tr>
<td>6. Is information on the circumstances:</td>
<td>Collected?</td>
</tr>
<tr>
<td>7. Is information about the type(s) of force used:</td>
<td>Collected?</td>
</tr>
</tbody>
</table>

**Key**
- **G**: Good
- **P**: Partial
- **L**: Limited
- **N**: None
- **U**: Unknown
- **N**: Not relevant

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**Data Quality of Official Sources**

<table>
<thead>
<tr>
<th>Question</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. How reliable are the sources used to produce official statistics about deaths?</td>
<td>P</td>
</tr>
<tr>
<td>9. Internal quality assurance / verification conducted</td>
<td>P</td>
</tr>
<tr>
<td>10. Methodology for data collection publicly specified</td>
<td>G</td>
</tr>
</tbody>
</table>

**Data Analysis and Lessons Learnt**

<table>
<thead>
<tr>
<th>Question</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. State / police agencies analyse data to generate evidence-based recommendations / lessons learnt, in order to prevent future deaths</td>
<td>L</td>
</tr>
<tr>
<td>13. Evidence that state / police agencies act on the results of their analysis, including applying lessons learnt</td>
<td>L</td>
</tr>
<tr>
<td>14. External bodies are able to reuse data for their own analyses</td>
<td>P</td>
</tr>
<tr>
<td>15. External, non-governmental agencies collect, and are able to publish, their own statistics on deaths following police use of force</td>
<td>N</td>
</tr>
</tbody>
</table>

**Investigations by Official Agencies**

<table>
<thead>
<tr>
<th>Question</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Is there a legal requirement for deaths to be independently investigated?</td>
<td>G</td>
</tr>
<tr>
<td>17. Is there an authority, separate from the one involved in the incident, which conducts investigations into deaths? If so, which organisation(s) conduct these investigations?</td>
<td>IPID</td>
</tr>
<tr>
<td>18. How independent are the investigations conducted by the organisation(s) named above? Please consider the extent to which they are independent and separate in terms of a) legal structure, b) hierarchy, c) investigative activity and personnel, d) operational ability (or ‘self-reliance’) e) oversight and control</td>
<td>P</td>
</tr>
<tr>
<td>19. Involvement of close relatives in the investigations</td>
<td>G</td>
</tr>
<tr>
<td>20. Investigation reports into deaths are:</td>
<td>L</td>
</tr>
<tr>
<td>Do they give reasons for the conclusions they have reached?</td>
<td>U</td>
</tr>
<tr>
<td>Is this a legal requirement?</td>
<td>No</td>
</tr>
<tr>
<td>Can such information be requested from the authorities via FOI laws?</td>
<td>G</td>
</tr>
<tr>
<td>Information available on legal proceedings against agents / officials pursuant to deaths</td>
<td>P</td>
</tr>
<tr>
<td>Information available on legal proceedings against state agencies pursuant to deaths</td>
<td>P</td>
</tr>
<tr>
<td>Information available on disciplinary proceedings against agents/ officials pursuant to deaths</td>
<td>P</td>
</tr>
<tr>
<td>Number of prosecutions against agents / officials involved in the last ten years?</td>
<td>★</td>
</tr>
<tr>
<td>Number of convictions against agents / officials involved in the last ten years?</td>
<td>▲</td>
</tr>
<tr>
<td>Number of prosecutions against agencies involved in the last ten years?</td>
<td>U</td>
</tr>
<tr>
<td>Number of convictions against agencies involved in the last ten years?</td>
<td>U</td>
</tr>
<tr>
<td>28. How readily available is information about prosecutions and convictions?</td>
<td>P</td>
</tr>
</tbody>
</table>

* ★: 560 for the 3 years FY 2016-17 to FY18-19. No data for previous years.
▲: 264 (FY 2009/10 to FY 2018/19).
Introduction

The South African Police Service (SAPS) is the centralised national policing body of South Africa, established by the Constitution and structured to function at national, provincial, and local levels of government. SAPS is headed by the National Commissioner of Police who is appointed by the President. Provincial Commissioners are also appointed in the nine provinces. At the end of the 2018/2019 financial year, SAPS had 192,277 members overall, including 150,855 South African Police Service Act (SAPS Act) members and 41,422 Public Service Act employees. This amounts to a police/population ratio of 1:1,383. In addition to these officers, in several of South Africa’s larger urban centres, local authorities maintain municipal police services, sometimes known as Metro Police (MPS). These officers have more limited statutory powers than members of SAPS.

Police recruits go through a Basic Police Development Learning Programme (BPDDL) for 24 months on different areas of policing, including firearms training according to the terms of the Firearms Control Act, 2000. The weapons available to members of SAPS vary by unit and context, but generally, the standard weapons available are pepper spray, a 9mm L85A2/Beretta pistol and an R5 carbine. Public Order Police are armed with pepper spray, stun grenades, a shotgun, a 9mm handgun with CS tear-gas grenades and a 40mm Lauchner provided to designated members. During the Commission of Inquiry following the events at Marikana in August 2012, SAPS leadership was challenged regarding officers’ use of assault rifles in crowd management and could not provide a satisfactory answer except to say the use of such rifles was permitted by law in circumstances of self-defence.

Section 1: Data Collection and Publication by Official Agencies

Data regarding the number and nature of deaths resulting from police action in South Africa (but not information on officers or victims) are consistently collected, periodically reported and publicly available. The main source of information is the Independent Police Investigative Directorate (IPID), a body legally mandated to investigate and report on various allegations of misconduct by SAPS, including deaths as a result of police action. These data are readily available and allow the number of deaths to be identified without the need for additional data processing. The data are anonymised. The deceased are not identified by name.

The demographic data for the deceased is collected but the information is not publicly available. The fact that the reporting forms used by SAPS members to report deaths as a result of police action or complaint forms submitted to IPID by members of the public require the inputting of demographic information shows that such information is available even though not public. It is not a legal requirement to make that information publicly available. Such information is protected from public disclosure under Chapter 4 of the Promotion of Access to Information Act of 2000 (PAIA).

The demographic data on the law enforcement officer(s) whose actions result in the death are also collected. Again, this data is protected under the Protection of Personal Information Act, 2013 (POPI Act), but it can be accessed through procedures outlined in the PAIA as above. Section 28(6) of the POPI Act prohibits responsible parties from disclosing personal information regarding the criminal behaviour of a data subject, in this case a police officer, to the extent that such information relates to the alleged commission by the data subject of any offence. The exceptions are outlined in Section 27 and include, among others, consent from the data subject or if processing is necessary for the establishment, exercise or defence of a right or obligation in law, or processing is necessary to comply with an obligation under public international law or for statistical or research purposes. Some of the demographic information becomes public as part of the summary of proceedings during civil or criminal proceedings in the courts on specific cases involving death as a result of police action. Some of the court cases are also reported in the media.

IPID collects and documents information on the circumstances of all reported deaths as a result of police action whether on or off duty. This information is published in IPID’s annual reports. Such information includes the circumstances under which police actions resulting in the death were taken as well as where the actual death occurred. For example, circumstances include “during the course of a crime”; “during the course of an escape”; “during the course of an investigation”; “during the course of an arrest”, or “crowd management incidents”. Examples of where the deaths occurred include “ambulances”; “court cell”; “crime scene”; “hospital”; “police cells” or “police vehicle”. However, while such information helps to provide context, it is on its own insufficient to understand the full circumstances leading to the officers’ decision to use force, and hence to determine whether or not the death was lawful.

IPID also collects information on the type of force used in each death recorded as a result of police action. This is a legal requirement under Section 9(6) and (n) of the IPID Act. While most incidents are caused by shootings with service firearms, some of the categorisations of types of force such as “assault” and “suffocation” may require additional clarity as to the exact type of force used. However, such information can be requested under access to information legislation referred to above.

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75 Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), sec. 207(1)-(2). At Cabinet level, the ministerial responsibility for policing sits with the Minister of Police.
76 The SAPS Act is the law that provides for the establishment, organisation, regulation and control of the South African Police Service.
77 The Public Service Act provides for the organization and administration of the South African public service, the regulation of the conditions of employment, terms of office, discipline, retirement and discharge of public service employees.
82 National Instruction 4 of 2014, (Public Order Police: Crowd Management during Public Gatherings and Demonstrations), Instruction, 12(5). POP members should at least have all the weapons listed but force may only be used by trained members in a coordinated manner and on command except in instances of private defence (see 14(2)). In terms of using live ammunition, only approved rounds may be used on command (see 14(7)).
84 Evans, S. (2014). Follow: Police use of deadly RE rifles: ‘unacceptable’ 10 September; retrieved from https://mg.co.za/article/2014-09-10-police-should-continue-to-use-re-
85 See http://www.ipid.gov.za/
86 See IPID Act 1.38
88 PAIA as above. Section 28(6) of the POPI Act prohibits responsible parties from disclosing personal information regarding the criminal behaviour of a data subject, in this case a police officer, to the extent that such information relates to the alleged commission by the data subject of any offence. The exceptions are outlined in Section 27 and include, among others, consent from the data subject or if processing is necessary for the establishment, exercise or defence of a right or obligation in law, or processing is necessary to comply with an obligation under public international law or for statistical or research purposes. Some of the demographic information becomes public as part of the summary of proceedings during civil or criminal proceedings in the courts on specific cases involving death as a result of police action. Some of the court cases are also reported in the media.
89 For example, Section 63(1) of the PAIA protects access to information of third parties (including the deceased) from being processed and Section 67 prohibits access to personal information if the record is pricked from production in legal proceedings unless the person entitled to the privilege has waived the privilege. According to Section 63(2)(d), exceptions include, among others, when the requested information about a deceased individual is done with the consent of the deceased’s next of kin, and Section 63(2)(e), when the information is already a public record.
Section 2: Data quality

The sources for intake figures, that is, the number of deaths as a result of police action reported to or subsequently identified by IPID are likely to be reliable. Under South African law, an unnatural or suspected unnatural death requires a two-part physical examination of the body of the deceased to be carried out by a qualified medical practitioner from the Forensic Pathological Service. The first is an external examination that focuses on the outer surface of the body (clothes and positioning of the body), then an examination of the surface of the body without clothes for signs of injury and, if required, samples of body tissue and x-rays are taken. The internal examination entails the inspection of internal organs of the body for evidence of trauma or diseases to assist in the determination of the cause of death and such information is noted in the autopsy report. The opening of a case dossier is either triggered by a public complaint or by a referral from a station commander or other SAPS or MPS members as required under Section 29 of the IPID Act. However, the reported data are not disaggregated by means of case intake. Post-mortem results for each deceased, which must be collected by the investigators, are then incorporated into the Investigative Process. However, in October 2019, a whistleblowing investigative journalism project, Viewfinder, provided evidence showing that there was widespread malpractice in terms of following IPID protocols on investigative processes, for example not attending the crime scene or collecting post-mortems as required in IPID’s Standard Operating Procedures. Such malpractice would not affect the intake numbers but it may impact other aspects of data quality, such as cause of death or demographic details.

IPID’s data quality assurance and verification processes are outlined in its Standard Operating Procedures Relating to Investigations and Firearms of 2019 (IPID SOPs). In theory, IPID SOPs outline the detailed process by which data is captured and its accuracy verified from the time a referral or complaint comes in. It starts with investigators who, upon receiving complaints or referrals, proceed to screen complaints/cases, consult the complainant or referral authority to verify the correctness of information supplied before registering the complaint/case on IPID’s Case Management System (CMS). This is followed by the work of the Case Intake Committee which, among other things, verifies each case to avoid duplicates, ensures that information is accurately captured on the CMS, classifies cases according to crime category as outlined in Section 28 of the IPID Act, gives directives in terms of what type of investigation must be undertaken, and assigns an investigator to each case. If the outlined processes are carried out with integrity, it ensures that the data are verified and their quality above reproach. The process looks robust but, as the Viewfinder investigation discussed above made clear, protocols are not always followed.

IPID’s methodology for data collection is publicly specified starting with the IPID with Section 9(d) and Section 28; IPID’s Technical Indicator Description for Annual Performance Plan 2019/2020 (TID 2019/2020).

As noted above, the intake statistics in respect of death as a result of police action, that is, the number of such deaths, is mostly reliable as far as is known to the authors of this report. However, the performance statistics are questionable. For example, according to a Viewfinder report, the challenge with the performance indicator for deaths as a result of police action outlined above is that since 2016, there is evidence that files have been moved from “active” to “completed” to inflate performance figures at the end of the financial year. As a result, these “completed” but poorly investigated dockets would be sent to the NPA who would send them back to the IPID with queries. At IPID, such dockets would not be reopened and “reactivated” nor would the statistics be rationalised to ensure IPID’s actual performance is reflected for that year. As a result, the IPID’s Case Management System continues to record them as complete and there is nothing done about them. Hence the claim by Viewfinder that the affected relatives of victims receive no justice and alleged perpetrators within the SAPS/MPs are not held accountable for such deaths in cases of arbitrary killings.

90 Inquests Act (Act 58 of 1959). Also refer to Regulations Regarding the Rendering of Forensic Pathology Service at: https://www.gov.za/documents/national-health-act-regulations-rendering-forensic-pathology-service. 91 Refer to the Inquests Act (Act 58 of 1959), Section 3(2), (3)(a) and (b).

92 Data collection is linked to the strategic outcomes of IPID and indicators of the organisation’s performance as required under the IPID Act. The methodology identifies the indicator measures and whether the performance reported is cumulative or non-cumulative as well as changes to indicators and whether IPID is performing better or poorly over time. For example, the strategic goal for deaths as a result of police action is stated as: “Number of investigations of deaths as a result of police action that are decision ready per year.” This is defined as the number of investigations where an investigator has conducted “quality” investigations and obtained all necessary evidence to be able either to refer the case to the National Prosecuting Authority (NPA) for decision or to make some kind of recommendation (for example, to the SAPS/MP) within a specified period – the baseline stated objective being 90 days.


95 Note: the TID 2019-2020 was developed a year after the year in question for this research. Available at: http://www.ipid.gov.za/content/technical-indicator-description-annual-performance-plan-20192020.pdf.
Section 3: Data analysis and lessons learnt

Police agencies (SAPS/MPS), IPID and the Civilian Secretariat for Policing Service (CSPS) cooperate, collaborate, collect, and share data including deaths as a result of police action but none of the available information illustrates that the data they have is analysed to generate evidence-based recommendations or lessons learnt in order to prevent future deaths. One would expect the CSPS, whose mandate includes, among other things, conducting quality assessments of the police service and monitoring and evaluating its performance and recommending corrective measures (See Section 6(1) and 6(2)(b) of the CSPS Act, 2011), to carry out this function. A reading of CSPS’s annual reports, annual performance plans, strategic plans, and regulations provides no evidence that they are informed by evidence from the data they collect. Monitoring and evaluation is done to illustrate “outputs efficiency”, that is, to count the number of activities completed per year based on predetermined output indicators and targets. This provides evidence of institutional compliance with legislative and policy directives which is seen as a measure of institutional performance. The analysis and use of data does not directly deal with outcomes-related lessons learnt in terms of which strategies for preventing the number deaths as a result of police action can be designed and put in place.

As observed above, there does not seem to be an analysis of the data and extracting lessons to be learnt from it. The presentation of the raw data seems to be an end in itself rather than the starting point for analyses that lead to the identification of lessons learnt, and recommendations for reforms or change of police tactics and practice. For example, a reading of the SAPS’ Strategic Plan 2025; the SAPS Research Division’s agenda and SAPS Annual Reports do not indicate that SAPS act on results of their analysis nor do they identify lessons learnt in their plans. Research think tanks such as the Institute for Security Studies (ISS) have also observed that despite the considerable body of research that has been undertaken, it is not clear if findings and recommendations from such research are ever used and if so, under what circumstances. IPID, which receives complaints and investigates cases of death as a result of police actions, is seen by some as a starting point without teeth, understaffed, underfunded, and routinely ignored and frustrated by the non-cooperation of the police it is supposed to investigate. External bodies such as the ISS, African Policing Civilian Oversight Forum (APCOF), Viewfinder, academic institutions and the media can reuse the data from police agencies and the IPID to critique the data, develop their own analyses of key issues, identify possible lessons to learn from the data. They can also use such analyses as a basis for lobbying and advocacy work and to make recommendations for changes in South African police practices in respect of specific categories of crime, including deaths as a result of police action.

Section 4: Investigations by official agencies

There is a legal requirement for deaths to be independently investigated, and IPID is the independent constitutional body charged with doing so. Information on legal proceedings against officials pursuant to deaths is available but is incomplete. Statistical information on criminal proceedings resulting from investigations of police officials by IPID can be found in IPID annual reports. However, IPID does not provide information on civil claims against police officials. The evidence of civil proceedings against the SAPS can be found in its annual reports in the financial section under the line “Contingent Liabilities (claims against the department)”. This essentially means the total financial encumbrances of the SAPS and reflects all claims against the SAPS, not just for deaths as a result of police action. There is no information to indicate the specific claims in respect of deaths as a result of police action. The media is another source, but the information is not systematically collected.

There is no centralised information on legal proceedings against state agencies pursuant to deaths. The statistics on criminal proceedings provided by IPID are for individual criminal charges against individual police officers who, when found guilty, face individual criminal sanction. Claims against state agencies are normally included in civil lawsuits but, as noted above, such information is not disaggregated in terms of specific crimes such as death as a result of police action.

Information on disciplinary proceedings against officials pursuant to deaths is available in IPID annual reports. Such information is in the form of statistics regarding the number of disciplinary convictions, disciplinary acquittals and disciplinary recommendations referred to SAPS and MPS per crime category, including deaths as a result of police action. Additional data include whether or not the SAPS has initiated disciplinary action as per IPID.
recommendation (the legally mandated service standard is 30 days), what the verdict is, and what the next steps in relation to such proceedings are.

Data on the number of prosecutions against officers involved in fatalities during the last ten years are not publicly available. From FY2016-2017, IPID started recording cases that are still on the court roll and disaggregated by charge, which includes death as result of police action. However, cases that carry over from previous years are included in the following year, making it difficult to calculate separate data for each year. As observed above, this relates only to criminal cases referred for prosecution by IPID; it excludes proceedings for civil claims made against individual police officers.

Over the last 10 years (FY 2009-2010 to FY 2018-2019), there have been 264 convictions against officers from both the SAPs and MPS for deaths as a result of police action. This number is not disaggregated by agency and excludes any civil proceedings which may have found that an officer acted unlawfully.

The number of legal proceedings against agencies in the last ten years is not available (neither is there information about outcomes of such proceedings). IPID Annual Reports do not present data by agency and IPID deals with criminal cases against individual officers and not the SAPS or MPS as agencies. IPID does not report on civil suits which is where, in most cases, prosecution is against both the officer involved and the Minister of Police. But, as the “contingent liabilities” data referred to above are presented in financial terms and not number of prosecutions, that information is not available either.

In theory, and according to regulations, regulations are supposed to be involved. Regulation 3(1) of the IPID Regulations states that, after a death is reported, the investigator should, within 24 hours, “visit the deceased’s next-of-kin to inform them of the death and to obtain statements that may assist in the investigation.” However, there are no data regarding the extent to which this potential performance indicator is achieved (and the recent Viewfinder exposé cast doubt over whether the procedure is always followed).115

Investigation reports into deaths are not publicly available and it is not a legal requirement to make them publicly available. The reports can be made available through a public information request in line with the Protection of Access to Information Act (PAIA) subject to limitations outlined in Chapter 4 of the Promotion of Access to Information Act and Sections 26(1) and 27 of the POPI Act.

The independence of the IPID is a diluted form of independence that is vulnerable to political interference. The institution’s independence has at times been rescued by independent, independent-minded leadership, and by the courts. In theory IPID’s role as an “independent police complaints” body is guaranteed in Section 206(6) of the Constitution of the Republic of South Africa. However, unlike similar institutions (commonly referred to as Chapter 9 institutions in South Africa) which report to parliament, IPID is established through an Act of Parliament, which made it responsible to the Minister of Police, thus significantly limiting IPID’s political autonomy from SAPS.115

As a result, the extent to which IPID is able authoritatively to determine its own priorities, programmes and projects is therefore doubted. It also relies on the Minister of Police for its budget allocation.116 IPID’s investigative programme is also severely underfunded, understaffed, and lacking in certain specialised skills.117 This limited investigative capacity means that IPID relies on SAPS, both directly (for forensic and ballistic analysis investigations) and indirectly, in certain cases, for investigative capacity.118

IPID cannot meet its mandate.116 IPID investigators are also often undermined by the police’s refusal to cooperate with investigations and even instituting counter-investigations of IPID investigators.117

An important determinant of independence of institutions such as IPID is of course its leadership, and their freedom to determine policies, programmes, operational methods, and activities as well as make findings, conclusions and recommendations. This aspect of independence is one that has been affected by the political interference of the executive including through Section 6 of the IPID Act that allowed the Minister to appoint, suspend and terminate the employment of senior IPID officers, such as the Executive Director and National Head of Investigations. A 2016 Constitutional Court ruling in McBride v Minister of Police invalidated certain provisions of Section 6 of the IPID Act, which had granted discretionary powers to the Minister of Police to suspend, take any disciplinary steps pursuant to the suspension, or remove from office, of the Executive Director.119 However, the subsequent amendments made to the IPID Act120 have left unchanged the Minister’s discretion to nominate a candidate for appointment to the position, thus potentially still undermining the principle of a clear, transparent and participatory selection and appointment process.

Section 5: Non-Official Sources

A desktop review of alternative, non-official sources of information on deaths as a result of police actions found no other sources that aim at collecting their own data about such deaths in a systematic way in South Africa, apart from IPID’s reporting.

The media are particularly focused on accountability for deaths as a result of police actions and Viewfinder is one of the most recent activist and advocacy organisations. Media coverage of deaths resulting from police use of potentially inappropriate force leading to serious injury or death focuses on anecdotes and does not attempt to systematically record and analyse all incidents of this nature. A simple google search with a search string such as “Police brutality in South Africa” provides evidence of the diversity of such coverage and analyses in the form of news, opinion, policy papers and academic writings.120 Technically nothing prevents external, non-governmental agencies or organisations from collecting and publishing such information. However, based on a thorough desktop research, there is no known external body that systematically collects such information in a holistic manner for the purpose of demonstrating such excesses nationally in South Africa.

There have been proposals, and preliminary efforts at creating a resource for the meta-analysis of IPID’s official data, but these have yet to become public.121

123 As of March 2021. For a discussion of the preliminary findings from the Viewfinder project, see the presentation of Daniel Knoetze at ‘Spotlight on South Africa’s police brutality problem’ (a seminar organised by the Institute for Security Studies, 4 August 2020) recording, available at: https://issAfrica.org/events/spotlight-on-south-africas-police-brutality-problem.
Recommendations

Regarding the official detection and investigation of cases

- IPID’s current overload of cases must be addressed, either by significantly increasing its resourcing; or by facilitating greater case prioritisation by thoroughly overhauling institutions for internal accountability within SAPS; or potentially both. Deaths following police contact should remain clearly within the investigative mandate of IPID, but by enhancing their capacity they would be able to address these cases with greater effectiveness.

- Parliament should consider the merits of making IPID a “Chapter Nine” institution (an institution with constitutionally-protected independence) rather than maintaining it under the Minister of Police, or consider other legislative safeguards to enhance its independence.

- In addition to its current performance indicator relating to investigations being decision-ready within a given time period (which incentivises investigators to ensure that investigations do not remain “open” for unduly long periods of time), IPID should consider a further performance indicator related to the intervening time between a death and the beginning of an investigation into that death. This could be something similar to “Proportion of investigations into deaths following police contact started within 24hrs of the event”. This would incentivise investigators to begin a greater proportion of investigations on their own initiative, and contribute toward a more comprehensive intake, as well as dramatically improving the quality of physical and witness evidence available to the investigation. Moreover, this could form part of a broader reform of IPID’s performance indicators to focus more on impact and outcomes rather than on procedural outputs; these could focus on IPID’s efficacy, public credibility, and its accessibility.

Regarding the public reporting of cases

- In addition to its Annual Reports, IPID should consider the publication of a dedicated statistical release concerning deaths as a result of police action. This publication could on a periodic basis (and with relevant safeguards for the protection of personal information) present more detailed demographic and contextual information concerning the circumstances that deaths arise, and present relevant recommendations with greater emphasis than can be appropriate in an Annual Report. This release could also helpfully describe the reasons for which investigations are closed, either for lack of evidence or for “no case to answer”.

- IPID should consider enhancing the frequency and profile of its public communications concerning specific cases, so as to ensure that it maintains its recognition in the public eye as an independent source of information about police conduct.

Regarding the institutional/policy response to cases

- IPID should consider establishing a proactive oversight unit that could learn lessons from its investigations and be a source of independent research and analysis of trends.

- The Civilian Secretariat for Police should more actively play its role of facilitating exchange about quality assessment of the service delivery of the police, facilitating engagement between IPID and SAPS concerning policy recommendations.

- The Parliamentary Portfolio Committee should monitor and require reporting from SAPS about efforts to implement such recommendations.
An Agenda for the Future

**Toward a Lethal Force Monitor** contributes to ongoing efforts by state bodies, police, non-governmental organisations, academics and others to develop a structured approach guided by human rights standards, principles and good practice to allow meaningful monitoring of the use of lethal force.

It has examined the policies and practices in place in Kenya and South Africa to collect, analyse and publicize data on lethal force used by law enforcement officials. In this final section we reflect on those two country reports in conjunction with the findings of the previous report on Western European jurisdictions in order to outline some underlying methodological components and guidelines that can support future research.

In relation to both of these reports, the ability to apply a common set of questions across the various jurisdictions in diverse contexts has been aided by the existence of three layers of attributes that all of the systems studied have in common. First, albeit with differing traditions and historical experiences, all of the jurisdictions considered are democracies under the rule of law, respecting at least in principle the values of accountability and openness.

Second, all of these jurisdictions share an adherence to international legal obligations deriving from the UN’s International Covenant on Civil and Political Rights. These obligations – including the need to investigate any death potentially involving a law enforcement official – have been clarified in various soft law instruments, including most saliently the Basic Principles on the Use of Force and Firearms, more recently in the Human Rights Committee’s General Comment No.36 and, more practically, in the Minnesota Protocol on the Investigation of Potentially Unlawful Death. In addition to these global standards, the Western European systems addressed also share the legal frameworks in the different jurisdictions where the police themselves (through, for example, internal affairs units) are responsible for the investigation of such deaths. Consequently, whilst noting the legal, socio-economic and political specifics that differentiate these jurisdictions, these institutional similarities open the way towards the possibility of broadly comparative evaluations.

Third, all of the systems have dedicated oversight procedures for their law enforcement agencies. With the exception of France, those procedures are run by agencies with some level of independence from the relevant police forces. Though the different oversight bodies operate with differing degrees of efficacy across the six jurisdictions, the existence of such institutions creates a bureaucratic architecture for the study of deaths following police contact that will likely be quite distinct from jurisdictions where the police themselves (through, for example, internal affairs units) are responsible for the investigation of such deaths.

However, the comparisons that have been undertaken through Toward a Lethal Force Monitor and Police Lethal Force and Accountability are provisional and limited in nature. They have been provisional because the evaluations made of the policies and practices within jurisdictions have relied on indicative classifications that have not been made according to a standardised evaluation framework. In addition, the evaluation criteria were derived by the research team. Further consultation and discussion with a range of stakeholders, including those affected by police use of force, oversight bodies, police agencies and others is needed to develop the project. The comparisons have been limited because they have only been made of a small set of jurisdictions that share the characteristics noted in the previous paragraph. Due to the independent oversight mechanisms in place, the types of policies and practices surveyed are likely to differ from the policies and practices in jurisdictions without such institutions. Also, the comparisons have been limited because they have not considered salient contextual factors related to the prevalence of the use of force by law enforcement agencies (such as the number of firearms among the general population and the variety of legal regimes in the different jurisdictions relating to firearm possession and the justification of lethal or potentially lethal use of force in law enforcement).

In response to these points of note, this final section identifies key issues associated with future attempts to assess the availability and reliability of official data about lethal force. In doing so, it sets out considerations that can inform the development of an international Lethal Force Monitor. In keeping with the content of this report, the points below only relate to the rating of official data.

Other potential aspects of a Lethal Force Monitor – such as compiling data on deaths from non-official sources (e.g., news reports or eye witness accounts), comparative analyses of official and non-official reports and perspectives, or including circumstantial summaries to suture data in context – are not addressed here.

To begin, it is important to identify the reasons why a Lethal Force Monitor is useful. The starting premise of this report is that producing detailed, reliable, and publicly accessible information for each individual death and deaths overall in a jurisdiction is a necessary, but not sufficient, step in ensuring the accountability of law enforcement agencies, ministries and governments. It can also play a vital role in understanding, quantifying and evidencing the ways in which particular groups in society can be disproportionately affected by police use of lethal force across the world, whatever the assumed or established (un)lawfulness of that force.

In identifying significant deficiencies associated with the use of force reporting policies and practices of law enforcement officials in South Africa and Kenya, Toward a Lethal Force Monitor underscores the importance of establishing a benchmarking methodology for consistent assessments of the reliability and accessibility of reporting and recording activities. The need for such methodology will become ever more pronounced as the range of countries expands beyond those with shared characteristics considered in this report and in Police Lethal Force and Accountability. In particular, the benchmarking will need to extend to further gauging the independence of police oversight agencies. Also, it will need to be able to characterise the forms of uncertainty and ambiguity associated with existing data on lethal force.

In what follows we propose some of the principles that could underpin the methodology of a future comprehensive, Lethal Force Monitor:

### Negotiated Consistency

In order to facilitate comparison between jurisdictions, any benchmarking methodology must establish shared standards for evaluation. The importance of doing so, however, needs to be balanced against the need for flexibility in assessing data. Additional information may be tailored as appropriate in relation to specific countries’ needs while ensuring overall data harmonisation. For example, though a Monitor might not encompass an appraisal of the policies and practices in place for assessing disappearances in all the jurisdictions analysed, such information may be included for specific countries when this activity takes place at scale with the assistance or complicity of law enforcement agencies.

As such, a Monitor needs to balance establishing common criteria for evaluation with the requirement of being responsive to local situations and conditions.

### Clarity and Transparency

Those evaluating the official data and data generating techniques need to make their assumptions, definitions and methodologies, as well as the criteria for excluding and including deaths, as explicit as possible. Doing so will not only enable others to assess the evaluations made but also underpin confidence in the conclusions reached. For instance, the criteria used in this and the previous reports have been driven by a set of guiding principles:

- Every death associated with the use of force by law enforcement officials should be recorded, recognised and investigated. No one’s death should go unacknowledged and any lessons should not go unexamined.
- Jurisdictions should have a clearly designated agency responsible for providing official data.
- Investigations should be independent and impartial. They should consider the actions taken on the ground as well as the relevant chain of command.
- Surviving family members and others directly affected by bereavement should be engaged in a meaningful way with investigation processes and subsequent outcomes.122
- State agencies need to establish and publicise systematic procedures for monitoring and reducing harms (especially deaths) associated with the use of force. This should include

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122 Beyond the limitations of engagement noted in this report, see as well the previous Police Lethal Force and Accountability: Monitoring Deaths in Western Europe report.
An Agenda for the Future

the elaboration of whether and how the lawfulness of such deaths and / or uses of force was determined.

- Ensuring practices are in-line with the letter and spirit of relevant national and international laws, codes and standards is an important part of achieving these objectives, but so too is the willingness to recognise how such laws, codes and standards need to be improved.

The foundations, necessity and sufficiency of such principles needs considered attention. Being explicit about assumptions, definitions, limitations, methodologies and other considerations will also enable better understanding of the legal and institutional frameworks, as well as policies and practices, associated with lethal force in specific countries.

Relatedly, there is a need for transparency around the aims and guiding principles of the project (as detailed above). The identity, status and affiliation of those who are involved in the work, and other important issues including the nature and type of funding, timescales and timeframes considered, and the availability and public accessibility of outcomes and reports should also be transparent.

Similarly, to ensure maximum comparative utility, compilers of individual jurisdiction reports will need to present information that is comprehensible not only to end-users within that same system, but also others for whom it might not be familiar. As any future Monitor is likely to involve contributors from different academic disciplines, professions and analytical perspectives, this sort of clarity in explanation and presentation may also need to encompass self-awareness of different working practices and areas of focus on the part of those compiling reports, so that their choices and approaches are made explicit.

Inclusion

Those evaluating data and assessing practices in the subject jurisdictions will need to take account of the rights, requirements and interests of different stakeholders involved in, or affected by, the use of force. The methodologies used to collect and evaluate data will be developed internationally, through collaboration with regional, national and local stakeholders. Such stakeholders might include government agencies, law enforcement bodies, non-governmental organisations, and representatives of bereaved families or otherwise affected citizens. This inclusion of a broad range of partners will ensure that the research design, data collection, and capacity development activities, as well as potential applications of research findings, are appropriately responsive to jurisdiction-specific variations (see ‘Negotiated Consistency’ above) as well as responsive to the needs of potential beneficiaries. In addition, with reference to worldwide and ongoing concerns about the need to decolonise research and international co-operation, those involved in developing the Monitor will need to keep in mind the importance of respecting others’ working practices and experiences, and minimising perceived (cultural or political) hierarchies in project construction. As such, the Monitor should strive to be empowering, participatory, locally owned and inclusive.

Given the focus on deaths resulting from or associated with the use of force, the nature of fatalities must also be addressed. Full consideration should be given to gathering information, where possible and appropriate, on the gender, ethnicity, physical or sensory attributes, socio-demographic characteristics and other locally relevant characteristics of victims. In such a way, a Monitor can work to progress knowledge and understanding around whether, and if so to what extent, marginalised groups might be more at risk from state uses of force.

The focus on deaths needs to be accompanied by an awareness that fatalities are not merely statistics, but deceased individuals for whom in many situations there will be bereaved family members, friends and others personally affected by the loss. A future Monitor’s inclusivity needs to encompass those affected by deaths and to find ways to involve family members and their experiences in the project, including in sharing information, in establishing how to represent and examine data about deaths in a humane and dignified manner, and in engaging with the evaluation of investigative and lesson-learning procedures.

Ethical Integrity

All aspects of the Monitor must comply with national and international ethical requirements for the handling of personal data, engagement with any human research subjects (such as interviewees or witnesses) and representation of personal experiences, as well as standards of good academic practice. Where any original data is gathered, contributors will need to comply with their own institutional or national ethical procedures. Similarly, all contributors will need to discuss and agree on their approach to authorship, subject to the co-operative nature of each report, and to acknowledge it as appropriate.

Sustainability

As a future Monitor expands, consideration will need to be given to the demands of its sustainability. Evaluative reports based on one data recording period will not suffice if state practices subsequently change or institutions and processes are altered. For a future Monitor to remain valid and useful over time, it will need a robust system of regular updating and amending as systems change, as well as local, national and international ownership and support. In so doing, the Monitor will be capable of engaging (including potentially directly, by way of complementary hyperlinking) with other comparable or related research endeavours, such as the global database on the Law on Police Use of Force Worldwide,123 and with specific analytic projects.124

By identifying such issues associated with the development of an international Lethal Force Monitor, this report is intended to provide some suggestions and guidelines for this crucially important area of work. Ultimately, a Lethal Force Monitor should enable governments, law enforcement agencies, non-governmental organisations, community groups and others to have sound information with which they can identify priorities to ensure lethal force is being thoroughly, accurately and publicly recorded and reported in their country or region. It should also assist them to understand how those practices compare to other jurisdictions and support them in building a stronger case for ensuring accountability for the use of force.

123 https://www.policinglaw.info/