HM Government

Government response to the Independent Review of Deaths and Serious Incidents in Police Custody

October 2017

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Foreword

When the Rt Hon Theresa May MP announced a major review of deaths and serious incidents in police custody on 23 July 2015, she focussed on the experiences of bereaved families. Her meetings with the relatives of Olaseni Lewis and Sean Rigg had left her in no doubt that there was still significant work to do: not only in preventing deaths in police custody but, where they do occur, ensuring that families and the wider public are given answers as promptly as possible and that lessons are learned.

By making families' experiences the basis of her investigations, the Rt Hon Dame Elish Angiolini DBE QC has afforded a central role to a perspective that, in the past, has been all too often forgotten. I would like to take this opportunity to thank the families who contributed to this review and to commend their resolute pursuit for answers. Often, their motivation is simply to ensure that lessons are learned in order to spare others the suffering they have endured. In this modest ambition, the Government stands with them.

This Government is committed to learning lessons and delivering change.

Dame Elish's report is comprehensive and identifies room for improvement in every aspect of the procedures and processes surrounding deaths and serious incidents in police custody. Her report is an important contribution to the wider debate on supporting bereaved families; more learning will come to the fore when Bishop James Jones reports on the Hillsborough families' experiences.

Dame Elish highlights a number of points of learning in relation to the inquest process. As a first step towards addressing these concerns and ensuring the bereaved can have confidence in the arrangements, the Lord Chancellor will review the existing guidance so that it is clear that the starting presumption is that legal aid should be awarded for representation of the bereaved at an inquest following the non-natural death or suicide of a person detained by police or in prison, subject to the overarching discretion of the Director of Legal Aid Casework. It will also be made clear that in exercising the discretion to disregard the means test, consideration should be given to the distress and anxiety caused to families of the bereaved in having to fill out complex forms to establish financial means following the death of a loved one. This work will be completed by the end of the year.

As a next step, the Lord Chancellor will consider the issue of publicly-funded legal advice and representation at inquests, in particular the application of the means test in these cases, as part of the upcoming post-implementation reviews of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, due to be published next year.

I am proud of this country's world-leading police forces. The vast majority of police officers in this country do their jobs well, putting themselves in harm's way to protect the public with honesty and integrity, upholding the values set out in the policing Code of Ethics. Police integrity and accountability is central to public confidence in policing and a system which holds police officers to account helps to guarantee this. The Government must ensure the public have confidence in the police to serve our communities and keep us safe.

When things go wrong, swift action is needed to expose and tackle any misconduct. Action must be open, fair and robust. We will implement legislation later this year to extend the disciplinary system to former officers so that, where serious wrongdoing is alleged, an investigation and subsequent disciplinary proceedings can continue until their conclusion, even where an officer has left the force. We will also make publically available a statutory Police Barred List of officers, special constables and staff who have been dismissed from the force and are barred from policing.

The Independent Police Complaints Commission (IPCC) has undergone a multi-year major change programme which has seen a five-fold increase in the number of independent investigations it opens each year compared to 2013/14. On Friday 20 October, we reached another major milestone in reforming the organisation with the announcement of the first Director General of the new Independent Office of Police Conduct (IOPC). The new Director General will start in January 2018 when the reforms to the IPCC's governance are implemented and it is officially renamed the IOPC.

We are strengthening safeguards in the custody environment. The Government is clear that police custody is no place for children. The Policing and Crime Act 2017 makes it unlawful to use a police station as a place of safety for anyone under 18 years of age in any circumstance, and we will shortly be implementing regulations to restrict the use of police stations as a place of safety for people aged 18 and over.

I am encouraged by the work of the College of Policing and the National Police Chiefs' Council to improve training and guidance for police officers and staff. Drawing also on learning from the IPPC's independent investigations, this has contributed to a significant reduction in the number of deaths in custody in recent years.

In other areas, however, improvements require us to tackle entrenched and longstanding problems that cut across multiple agencies' responsibilities. We must not shy away from the long-term collaborative work that this requires. That is why the Government has commissioned the Ministerial Council on Deaths in Custody to play a leading role in considering the most complex of Dame Elish's recommendations: those relating to healthcare in police custody, inquests and support for families.

The Ministerial Council is uniquely placed to drive progress in these areas and, in line with Dame Elish's recommendations, has been newly reformed to ensure an increased focus on effectively tackling the issues that matter most. It brings together not only ministers from the Home Office, the Department of Health and the Ministry of Justice, but also leading practitioners from the fields of policing, health, justice and the third sector. In addition, its work is informed by an Independent Advisory Panel which brings together eminent experts in the fields of law, human rights, medicine and mental health. This will introduce necessary oversight to ensure lessons are learnt.

In recognition of the need for increased scrutiny and accountability in the procedures surrounding deaths and serious incidents in police custody, I have written to Her Majesty's Chief Inspector of Constabulary; inviting his views on Dame Elish's findings and how we can further address failings and drive required improvements.

Every death in police custody is a tragedy. We must do all we can to prevent them. The Independent Review of Deaths and Serious Incidents in Police Custody is a major step forward in our efforts to better understand this issue and to bring about meaningful and lasting change.

I am very grateful to Dame Elish for her tireless efforts to shine a light on this important issue. I am also grateful to Deborah Coles, Director of INQUEST, and to Dame Elish's Reference Group for providing expert advice to the review, and to the great many experts, practitioners and family members who generously gave their time and support to producing this considered and thorough review.

The Rt Hon Amber Rudd MP
Home Secretary

1. Introduction

1.1. Deaths in, or following, police custody are defined as those deaths that happen whilst a person is under arrest or detained under the Mental Health Act 1983, or where a person is no longer detained but their death arises from injuries or medical problems that developed or were identified during their detention. This includes deaths that occur not only within a police custody suite, but also on private or medical premises, or in any other public place.

1.2. Natural causes have been the most common known cause of deaths in police custody in England and Wales between 2004/05 and 2014/15, accounting for 51 percent of causes of death in this period. Drugs and/or alcohol also featured as causes in around half of deaths (49%), and an even higher proportion of those who died had an association with drugs or alcohol (82%). Mental health is also a significant contributing factor; according to the latest annual statistics published by the Independent Police Complaints Commission (IPCC), eight out of 14 people who died in or following police custody were identified as having mental health concerns.[1] Use of restraint against detainees was identified as a cause of death by post-mortem reports in 10 per cent of deaths in police custody between 2004/05 and 2014/15. Those who die in police custody in England and Wales are typically male, aged between 31 and 50, and from a white ethnic background.

1.3. Since the 1990s, there have been large reductions in the number of deaths in or following police custody. This likely reflects improved training, guidance and practices in a number of areas,[2] but most significantly in suicide prevention, drawing on learning including from the IPCC's independent investigations. Recent Government initiatives have also limited the use of police cells as places of safety for mental health detentions (banning them entirely in the case of children and limiting them to exceptional circumstances for adults) and introduced more stringent governance and scrutiny of police use of force.

1.4. The focus of this Government is to go further still. It is essential that deaths and serious incidents in police custody are reduced as far as possible and, when they do occur, that they are investigated thoroughly, agencies are held to account, lessons are learned where improvements are identified, and bereaved families are provided with the support they need. It is for this reason that the Government commissioned the Independent Review of Deaths and Serious Incidents in Police Custody.

1.5. This response to the Independent Review sets out progress in those areas where Dame Elish Angiolini has made recommendations for change, including progress made since the review was commissioned in 2015. It also identifies where new initiatives or programmes of work have already commenced directly in response to the review's findings.

1.6. Whilst progress is outlined in the areas of healthcare in police custody, support for families and the inquest process, it is recognised that significant cross-agency work is required to develop solutions to these longstanding areas of concern. The newly-reformed Ministerial Council on Deaths in Custody will take these strands forward as priority areas within their

[1] IPCC (2017), *Deaths during or following police contact: Statistics for England and Wales 2016/17*. Available at https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1617.pdf

[2] For example, more stringent measures have been introduced in relation to regular cell checks, logging of checks on custody records, observations levels for the particularly vulnerable and better risk assessments of people entering custody.

programme of work. This will include close collaboration with the Welsh Government to take account of areas which cut across devolved competences.

1.7. The report of the Independent Review of Deaths and Serious Incidents in Police Custody makes 110 recommendations for improvement, categorised under twelve thematic headings: restraint, custody environment, health and wellbeing, funding for families and family support, communications, investigations, coroners and inquests, accountability, training, learning, statistics and research.

1.8. The recommendations fall to a number of Government departments and public sector organisations, and many of them are cross-cutting and multi-disciplinary in nature. In the following pages of this response, each of Dame Elish's thematic headings is addressed in turn, in order to ensure the recommendations are addressed in the round. The corresponding recommendation numbers are indicated in brackets at the end of the relevant paragraph.

2. Thematic Response

Restraint

2.1. The responsibilities of the police are to protect the public, prevent, detect and investigate crime and bring offenders to justice. There are some circumstances, such as when suspects are violent or resisting arrest, in which fulfilling these responsibilities may require the use of restraint, including to prevent harm to the public, to police officers or to the suspects themselves.

2.2. The extent to which restraint techniques contribute to deaths in custody and whether current training is fit for purpose is a crucial aspect of Dame Elish's report. IPCC statistics indicate that of 18 deaths in or following police custody in 2014/15, 10 followed use of restraint; in 2015/16, of 14 deaths in or following police custody, six followed the use of restraint; and in 2016/17, of 14 deaths in or following police custody, it is known that five people had some force used against them by officers or by members of the public before their deaths.[3, 4, 5]

2.3. Police training and practice must emphasise that under certain circumstances any form of restraint can potentially lead to death. This is particularly true in instances where a suspect is suffering from acute behavioural disorder (ABD), mental health crisis or the effects of drugs or alcohol. In these instances, the use of restraint – whilst sometimes necessary – may have the effect of aggravating the individual further, heightening the need for further restraint and increasing the risk that a medical emergency will arise. We must seek to break this cycle. [1]

2.4. The risks and best practice associated with positional asphyxia and ABD are firmly embedded in national police training. The National Police Chiefs' Council (NPCC) and the College of Policing aim to ensure that the latest medical, legal and tactical advice form a 'golden thread' that permeates throughout the National Personal Safety Manual, and this is especially so in relation to the challenges of prone restraint and mental health issues. Recent examples include the regular review of the medical implications of restraint by leading healthcare professionals and the introduction of a multi-agency training DVD, which is designed to promote safety in the police's partnership approach. [1, 3, 5, 6]

2.5. Guidance issued by the College of Policing through the National Acute Behavioural Disorder Package and National Personal Safety Manual provides officers and staff with knowledge and understanding to identify symptoms, respond effectively and manage an individual whom they consider to be suffering from ABD. If physical restraint is a necessary and proportionate response, officers and staff are trained in techniques that significantly reduce the potential for an individual to suffer from positional asphyxia. The College of Policing will ensure the term "Excited Delirium" is no longer used in guidance or training. [1, 2, 3, 4, 5, 6]

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[3] IPCC (2017), *Deaths during or following police contact: Statistics for England and Wales 2016/17*. Available at https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1617.pdf

[4] The use of restraint, or other types of force, did not necessarily contribute to the deaths.

[5] Of the five people who had some force used against them, one was physically restrained by the police. Four were being physically restrained by non-police, such as security staff or members of the public, when the police arrived at the scene; there was no police involvement in restraining the four people involved in these incidents, but the police did apply handcuffs when they arrived. IPCC (2017), *Deaths during or following police contact: Statistics for England and Wales 2016/17*.

2.6. The National Decision Model (NDM) is designed to help officers and staff ensure timely and proportionate 'use of force' decisions - often in complex and fast-moving circumstances. The policing Code of Ethics sits at the heart of the NDM, which is fundamental to the National Personal Safety Manual, training and guidance.

2.7. In response to recent coronial findings, the College of Policing has placed an increased emphasis on the concept of 'containment' and its application to many strands of policing (tactical communication, hostage negotiation, public order, firearms; etc.). Containment involves the use of de-escalation, persuasion and negotiation with the intention of resolving conflict without the need to use force. This concept features significantly in personal safety training. [2, 3, 5, 6]

2.8. In addition, the College of Policing is currently piloting a new approach to the development of guidelines. These guidelines on 'Safer Resolution' will provide recommendations for good practice, based on the best available evidence in order to support officers and staff to manage conflict without force. The research aims to understand better the factors that are associated with escalation or containment of conflict situations as well as effective techniques to de-escalate, diffuse conflict and 'slow down' situations. It is anticipated the new guidelines will be published in 2018. [2, 3, 5, 6]

2.9. In January 2017, the College of Policing published a Memorandum of Understanding (MOU) between the NPCC, the Royal College of Psychiatrists, the Royal College of Nursing, the Faculty of Forensic and Legal Medicine and Mind which addressed the issue of police restraint in mental health/learning disability settings. This helps to build a common understanding across agencies. Additionally, the College of Policing published guidance and training modules on the policing role in dealing with mental health in October 2016. This work is intended to support all in policing who may encounter people who need mental health support. [5, 6]

2.10. Through the continual development of guidance, training modules and standards, the College of Policing is supporting greater consistency of approach and enhanced standards across the 43 police forces in England and Wales. All Chief Constables, through the NPCC, have committed to working towards a nationally consistent approach to custody training, aiming for all custody practitioners to be trained to a national minimum standard. [2]

2.11. The NPCC and the College of Policing are working together to develop a national awareness initiative for frontline officers and staff, which they aim to launch this year. Drawing on known risk factors and the lessons learned from Dame Elish's report, the campaign isolates and publicises the key decisions that officers must take when considering whether the suspect should be dealt with as a medical emergency or conveyed to custody. The initiative aims to support the police by encouraging them to consider the potential risks of a difficult arrest at the earliest opportunity and take extra care to safeguard the suspect's welfare where restraint is unavoidable.

2.12. In recognition of the importance of ensuring transparency in how police forces use force, and in response to concerns that force is potentially being used disproportionately against vulnerable groups, the Government asked former Chief Constable David Shaw to review what data should be collected and published. The review recommended that forces record an extensive range of data in all instances when force is used, including the use of restraint techniques. Since April 2017, data has been collected by individual forces, including the age, gender, ethnicity and sex of the subject, the type of force used, reason for the use of force, and the outcome of the incident.

2.13. Police forces are now publishing their record level data locally on a quarterly basis and a subset of the key data will be provided to the Home Office for publication as part of the mandatory 2017/18 Annual Data Requirement – and annually thereafter. Publishing this level of data provides unparalleled levels of transparency over what force is being used by the police. It will improve the public understanding of why force is being used, where it is being used, and who it is being used on. This, in time, will increase public trust and confidence, and ensure greater police accountability.

2.14. The data recorded will also offer meaningful comparisons of the impacts of different techniques and tactics used by the police, including the level of injury suffered by the subject, and by police officers. This will directly influence, enhance and improve the effectiveness, legitimacy and consistency of future police training, tactics and equipment by shining a light on areas for improvement.

2.15. The development and introduction of new Personal Protective Equipment (PPE), including restraint equipment, is strictly controlled through the relevant NPCC Conflict Management portfolios, which have wide-ranging membership of senior police personnel and partner agencies (including Health Care Professionals and Independent Advisory Groups) to ensure a balanced and transparent process. The new use of force data, being published for the first time this year, will feed into this process. [7]

2.16. All officers must be trained in the use of PPE and demonstrate both physical competency and sound judgement within mandatory training programmes before the equipment is issued. Officers must also attend annual developmental training, which is 'pass or fail', to ensure national standards are maintained. Those that do not meet the required standards, which is relatively rare, are given action plans to help raise their development to the requisite standard. [2, 7]

Custody Environment

2.17. Police custody is important to protect the public and to enable the effective investigation of criminal offences. It may only be used where it is both necessary and proportionate to the investigation of an offence. Simultaneously, detainees in police custody are often among the most vulnerable individuals in our society and the state owes them a significant duty of care.

2.18. The Police and Criminal Evidence Act 1984 (PACE) and its Codes of Practice, as well as practitioner guidance issued by the College of Policing (referred to as Authorised Professional Practice), set out detailed parameters for use of the power of detention, designed to ensure adequate safeguards are in place.

2.19. The Detention and Custody Authorised Professional Practice (APP) has specific guidance on restraint, risk assessment, ABD and positional asphyxia, as well as other safety related matters. The College of Policing seeks to underpin all of its products with the best available evidence. This will increasingly ensure that policing practice and standards are based on knowledge, not custom and convention. Dame Elish's report will be used to further improve training, guidance and standards in relation to detention and custody. The evidence will be examined to see whether adopting a safety officer approach when restraint is used, such as that used in prison settings, could be effective in reducing injury and death in police custody settings. This will take into account the different operating environments and resourcing models that apply in police detention settings. [8]

2.20. To complement this body of legislation, standards and guidance, in October 2016, the NPCC approved and adopted the National Strategy for Police Custody, developed by Chief Constable Nick Ephgrave with the assistance of police and relevant partner agencies.[6] The strategy aims to provide a single vision for police custody in England, Wales and Northern Ireland to inform a nationally consistent approach to new initiatives, new investment and approved practice. The strategy sets out six principles for police custody:

i. Detention in Police Custody is safe and used only when necessary, not punitively;
ii. Custody supports effective investigation of crime and adds value to the criminal justice system;
iii. The custody experience is non-discriminatory and transparent for all that have engagement with the process;
iv. Custody practitioners are professionals in their field, trained to a national minimum standard and accountable for their actions;
v. Custody practice is ethical and evolves, reflective of changing demands, identified best practice and learning from previous failings;
vi. Engagement with partners is effective and efficient in the support of the investigation of crime.

2.21. Implementation of the National Strategy for Police Custody is overseen by the biannual National Custody Forum and driven through its five multi-agency working groups on Health, Training, Risk Assessment, Technology and Voluntary Attendance. The Forum comprises representatives of the police, academia, inspectorates and watchdogs and aims to identify and share best practice, respond to emerging issues in custody practice and to drive nationwide improvements in police custody.

2.22. The Strategy recognises that police custody is not always the appropriate response for an individual, even where there are statutory police powers for its use. Alternatives that recognise the individual needs of detainees, especially vulnerable detainees, must always be considered and the police must continue to strengthen work with partners in the medical and mental health fields to manage the needs of detainees and identify opportunities for early diversion from the criminal justice system. This includes seeking and obtaining medical input to the risk assessment process at the point of release, wherever possible. [12]

2.23. Among the most important safeguards available to those in police custody are Appropriate Adults,[7] who ensure that both children and vulnerable adults understand custody processes, and that their rights and entitlements are respected. The Government is aware of the difficulties that some police forces encounter to secure Appropriate Adult support in respect of vulnerable adults. This was a problem explored in some depth in the National Appropriate Adult Network (NAAN) report *There to Help: Ensuring provision of appropriate adults for mentally vulnerable adults detained or interviewed by police*, which was commissioned by the Government. In response, the Government set up a dedicated Working Group to consider the report's recommendations and develop solutions to the problems identified. Progress has been made to identify revisions to PACE Codes of Practice C (detention) and H (terrorism detention) to ensure that AA provision is targeted where it is needed. Work is currently underway to develop a partnership approach to commissioning Appropriate Adult services for vulnerable adults which will see Police and

[6] The National Strategy for Police Custody is available at http://www.npcc.police.uk/documents/NPCC%20Custody%20Strategy.pdf

[7] A parent, guardian or other adult (not employed by the police) whose role is to support, advise and assist juveniles and vulnerable adults in police custody with a view to safeguarding their rights, entitlements and welfare.

Crime Commissioners (PCCs) and Local Authorities working closely together to ensure that where an Appropriate Adult is needed, there is availability with minimal delay. The Government has also increased its annual grant to NAAN to enable it to provide a better service to those delivering AA services. [16]

2.24. Independent Custody Visitors (ICVs) also have a key role to play in safeguarding people detained in police custody. The Government provides an annual grant of £105,000 to the Independent Custody Visiting Association (ICVA), and has supported ICVA to undertake significant reform of its internal governance and training offer in order to ensure that local ICV schemes are as effective a safeguard as possible for those held in police custody. This has included working to improve the capacity and capability of ICVs to conduct unannounced inspections where suspects are held under the Terrorism Act 2006 (TACT). The Government will continue to work closely with ICVA to consider how the work of ICVs can be better aligned with national policy objectives and potentially the work of inspectorates like the Criminal Justice Joint Inspectorate (CJJI). [18]

2.25. The Government is clear that police custody is no place for children. The Policing and Crime Act 2017 will make it unlawful to use police cells as a place of safety for anybody below the age of 18 and £30m has been made available to local clinical commissioning group areas to ensure there is sufficient provision of community and health-based places of safety. In addition, all police forces and the majority of local authorities in England are signatories to the Home Office's Concordat on Children in Custody, which has been launched alongside this response. This represents their agreement to work together to ensure that children who are charged and denied bail are always transferred from police custody to local authority care when required. The Welsh Government has developed a bespoke version of the Concordat for forces and local authorities in Wales. [13, 15, 25, 90]

2.26. In addition, the Government is working to address capacity issues within the secure children's homes estate. The Government is committed to long-term change to ensure that secure children's home provision is better joined up at a national level to protect the interests of those very vulnerable young people in need of a secure placement. A national approach will enable better planning and coordination of placements, based on individual needs, and will look to address the current capacity issues. [13]

2.27. The Government continues to invest in the secure estate through the Secure Accommodation Capital Programme, worth £40m over the current spending review period, to ensure the provision meets young people's needs, and to expand capacity. The Government is also providing almost £5m of funding through the Children's Social Care Innovation Programme, to pilot new models of commissioning of residential care placements, in order to increase placement choice. [13]

2.28. The College of Policing Detention and Custody APP highlights the need for a different and distinct approach for female detainees and factors that should be considered, including child/dependent welfare issues and the effects of being separated from a child, where the detainee has a baby or infant. It also sets out standards for detainees with caring responsibilities (irrespective of gender), including an expectation that staff facilitate multiple phone calls to arrange alternative care arrangements, provided there is no investigative impediment. As well as ensuring all risks, vulnerabilities and welfare needs of detainees are being adequately managed, custody officers need to consider the risks that children could be exposed to in custody environments and the resourcing requirements of managing those risks in determining the best course of action. [17]

2.29. The Government supports measures that improve transparency and accountability. The decision to procure and deploy CCTV in police vans is a matter for PCCs and chief officers

as are issues related to its maintenance, and these decisions will be taken in the context of their force's technology strategy. [9]

2.30. Decisions related to the use of private sector detention service providers are also a matter for PCCs and chief officers who are responsible for ensuring their force is efficient and effective. PCCs and chief officers are responsible for setting standards and for making sure suppliers meet those standards. The College of Policing Detention and Custody APP requires that all contracted staff are adequately trained for their contracted role. However, to ensure that the overall system within which contracting occurs has appropriate checks and safeguards, in 2014, the Government extended the powers of the IPCC to cover contractors working for the police, and, in 2017, the Government also extended the powers of Her Majesty's Inspectorate of Constabulary & Fire and Rescue Services (HMICFRS) to cover contractors delivering policing functions. [19, 85]

Health and wellbeing

2.31. The particular challenges for policing in responding to people with mental health problems have been highlighted in a number of recent reports, including those published by Lord Adebowale (2013) and the Home Affairs Select Committee (2015). As Dame Elish notes: "The issue of mental ill health manifests itself time and again within the police custody context."

2.32. One in four British adults experiences at least one diagnosable mental health problem in any one year[8], and day to day policing brings officers into regular contact with individuals with mental health problems in a range of circumstances. Estimates put the proportion of total police time spent dealing with those with mental ill health issues at between 20% and 40%.[9]

2.33. The police sometimes encounter people at a point of mental health crisis, and it is imperative that such people receive the response most appropriate to their medical needs, as soon as possible. Custody facilities are designed for detaining people suspected of criminal offences, not for people suffering medical emergencies.

2.34. When a person with mental health problems needs to be taken to a police station, the police are held to a stringent set of requirements in relation to their safety and welfare, as underpinned by PACE and its associated Codes of Practice.

2.35. In 2014, the Government published the national Mental Health Crisis Care Concordat which clearly sets out the expected standard of response to people experiencing a mental health crisis. This was followed by the development of local concordat declarations and action plans by health, social care, policing and other partners throughout England. [29, 32]

2.36. As specified in the Crisis Care Concordat, local partnerships should also develop and maintain joint protocols to support an effective response, including timely access to health based places of safety for people detained under section 135 or 136 of the Mental Health Act 1983. Local partners should be jointly planning for implementation of the upcoming changes to section 135 and 136. The use of health-based places of safety has increased, in line with a significant reduction in the use of police stations (police stations were used 2,100 times during 2015/16; this represents a 54% reduction against 2014/15 when they were used 4,537 times). The Government has supported this through significant investment

[8] The Office for National Statistics Psychiatric Morbidity report, 2001 (quoted by the Mental Health Foundation)
[9] Independent Commission on Mental Health and Policing Report (May 2013 Lord Adebowale for the MPS)

in new places of safety capacity: £15 million in 2016/17, with up to £15 million more committed for 2017/18. [25, 27, 28, 32]

2.37. A number of amendments to the police powers and place of safety provisions in the Mental Health Act 1983 will help to improve the response in cases where the police are involved. Police officers will be required to consult (where practicable) a health professional before using section 136. When section 135 or 136 powers are used, the maximum period of detention will be reduced from 72 hours to 24 hours, and the use of police stations as places of safety for under 18s will be banned, and further restricted in the case of adults. These changes are expected to commence before the end of 2017. [25]

2.38. The Government wants to stop police officers being used in place of medical professionals when dealing with people in mental health crisis, and locally developed joint initiatives now operate in the majority of police force areas in England and Wales with this aim. In particular, "street triage" schemes bring together health and police professionals to respond more effectively to crisis incidents, and most police forces now have access to such schemes. These services help police officers to benefit from the specialist support of health professionals (particularly through expert advice, access to information, and the ability to facilitate access to care pathways) in dealing with a person in crisis and to make properly informed decisions as to the best course of action, including whether formal detention under the Mental Health Act is necessary. [20, 26]

2.39. Where a person (with any type of health problem) needs to be taken to a hospital or other health facility for treatment, they should be transported by ambulance and police vehicles should not be used, except in the most extenuating circumstances. The Government is encouraging the emergency services to collaborate to ensure that each service responds appropriately in such cases, including through the operation of joint initiatives. Section 136 Mental Health Act detentions are a particular case in point, with a 30 minute response time target established by the Association of Ambulance Chief Executives in 2014 and the police are now collecting more data on their involvement in such cases. [6, 24]

2.40. The Government is clear that health partners should take primary responsibility when restraint is required in relation to a person receiving treatment or other care in a mental health setting. Local agreements should clarify the limited involvement of police officers in these situations – which must be in line with their powers, for example where an allegation of a criminal offence needs to be investigated – in line with the principles of the national Memorandum of Understanding published by the College of Policing in January 2017. [20, 29]

2.41. In commissioning custody healthcare services, PCCs are informed by a range of guidance, including a NHS England national service specification, which sets out expected clinical standards, and College of Policing Authorised Professional Practice on Custody and Detention, which references a range of wider guidance published by professional bodies. In addition, many local forces have close relationships with local NHS England commissioners and service providers, which have helped to enhance service standards and delivery. In many areas, local partnership boards with attendance by police forces, NHS Commissioners and other key partners maintain oversight and governance of these commissioning arrangements. The Government believes these arrangements properly ensure that custody health services are able to be prioritised in accordance with the needs of those in police custody, but it is essential that any issues in provision are fully understood and addressed. [31]

2.42. In addition, Liaison and Diversion (L&D) services are being rolled out in police stations and courts, and are currently expected to cover 82% of the population by the end of 2017/18 with a view to 100% coverage by 2021. These services identify and assess people arrested

for an offence who may have mental health or substance misuse issues, or other vulnerabilities, and aim to divert them into services and/or away from custody (if appropriate). L&D services are not treatment services, but an assessment and identification service that makes necessary referrals to treatment and informs criminal justice practitioners about the health issues identified, for use in their decision making. [26]

2.43. L&D services play an important role in addressing a number of key Government priorities – the Government response to the Five Year Forward View on Mental Health stated that the Ministry of Justice will work with NHS England, the Department of Health, Public Health England and the Home Office to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.

2.44. NHS services are provided free at the point of delivery and based on clinical need. Treatment should not be refused on the basis of a person's presentation to services but we acknowledge that anti-social and violent behaviour puts the safety of health professionals and other patients at risk and is costly to the NHS. NHS Protect published a joint working agreement in 2011 between the NPCC, the CPS and NHS Protect on 'Tackling Violence and Anti-Social Behaviour in the NHS'. [21, 23]

2.45. The purpose of the protocol is to put in place a broad framework to assist local units of the three national organisations (the NPCC, the CPS and the NHS) in setting up closer working arrangements to reduce the problem of violence and anti-social behaviour affecting the NHS, including drunken behaviour. Incidents involving mentally disordered persons are another key area where improvements in joint working are required. Cooperation is essential, not just to deal with the offender and support the victim, but to seek to reduce levels of violence in order that the majority of patients receiving mental health services, who are not violent or abusive, can receive care in a safe and therapeutic environment. As is made clear in the protocol, the content of local agreements is a matter for local negotiation. All three organisations are committed to supporting the development of local agreements at whatever level proves to be best for the parties involved. [21, 23]

2.46. In relation to the design of A&E facilities, local health services are best placed to design A&E services to suit the needs of their patients, including arrangements with other local stakeholders. The Department of Health has issued building design guidance to the NHS in relation to A&E facilities which includes a wide-range of design considerations to meet the varied and complex needs of people presenting at A&E: this includes making effective use of space to ensure the safety of patients and staff whilst maintaining high quality services. [22]

2.47. Local authorities and health and wellbeing boards are best placed to understand and plan local alcohol services to address the complex issues of harmful drinking and alcohol dependency in their communities. Alcohol treatment for harmful and dependent drinkers should be an essential element in the broader range of alcohol policies and interventions. These issues should be addressed through local Joint Strategic Needs Assessments (JSNA). Public Health England has published JSNA Support packs to assist local areas in their planning, including for alcohol services. Effective local systems will be those that are coherently planned by local government, NHS and criminal justice partners to provide clear, integrated policies and pathways through levels of intervention based on identified need. To address the harm, costs and burden on public services from alcohol misuse, successful plans will take into account local needs and community assets assessments, and will reflect evidence of what is known to work in terms of effective interventions for those at risk, treatment and recovery services for dependent drinkers, and action to reduce binge drinking and reduce the harm caused by binge drinkers. [23]

2.48. The Department of Health published guidance to the NHS in 2015 on meeting the requirements of Article 2 of the European Convention of Human Rights in relation to investigating serious incidents and this guidance should be read in conjunction with the NHS Serious Incident Framework (2015). The guidance states that in NHS services, providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay. However, providers are responsible for ensuring that there is an appropriate investigation into the death of a patient detained under the Mental Health Act (1983) (or where the Mental Capacity Act (2005) applies). Providers should consider commissioning an independent investigation in line with the Serious Incident Framework guidance and the Department of Health's guidance on meeting requirements of Article 2. The guidance also states that there should be early discussions between NHS providers and other agencies (such as the police) who may have been involved in the incident to avoid duplication, and ensure co-operation so that incidents are investigated appropriately and thoroughly. [30]

2.49. The interplay between policing and healthcare is complex and multi-faceted, and will increase as our understanding of mental health issues continues to improve. That is why the Government has commissioned the Ministerial Council on Deaths in Custody to oversee a programme of cross-Government work to better understand the current state of healthcare in police custody and to work towards improvements, recognising that success will require the ongoing collaboration of multiple partners from a range of disciplines.

Funding for families and family support

2.50. Among the Independent Review's most significant findings are those relating to the problems bereaved families experience in the immediate aftermath of their relative's death and their experience of the subsequent inquest.[10]

2.51. As Dame Elish highlights: "Many bereaved families have very poor experiences of post-death procedures at a time of great trauma and vulnerability and in circumstances that are out with their previous experiences... the evidence provided to this review showed that the degree of assistance families receive is *ad hoc*, with some left isolated and alone while others are able to secure good quality advice and support through working with groups such as INQUEST and specialist lawyers."

2.52. The Government recognises that some improvements must be made. The trauma of learning that a loved one has died in police custody must not be compounded by confusion, lack of support and – in some cases – fear that meaningful participation in the inquest process may come with a financial burden. The Government is, of course, mindful of the role of the coroner as an independent judicial officer, rather than an agent of the state and of the resource implications for the police, pathologists and mortuary services as well as coroner services of recommendations such as mandatory video and audio recording of post-mortem examinations and providing designated areas for families. [35, 37, 43].

2.53. The Government will work with the Chief Coroner to ensure that the fullest possible information is available to families about the practical and legal issues that arise after a death in police custody over and above what is already provided in the Ministry of Justice *Guide to Coroner Services*; for example, by reinforcing requirements in the Coroners (Investigation) Regulations to notify families about post-mortems, and by working with coroners and relevant agencies to ensure full information about support services is available. [36, 41, 42, 45]

[10] Recommendation 33 is addressed in the *coroners and inquests* section.

2.54. In addition, in cases where there is a potential for a charge of murder or manslaughter, bereaved family members are entitled to the support of the MoJ funded national Homicide Service. This offers practical and emotional support, and where needed will refer bereaved individuals to free of charge specialist therapy (trauma and bereavement counselling) provision. [41]

2.55. The Government will likewise work with the Chief Coroner to support a presumption that families should have access to the body of the deceased as soon as possible, and to ensure that reasons are given where this is not possible; and to support use of pre-inquest hearings where appropriate. [44, 49, 52]

2.56. The National Guidance on Learning from Deaths (2017) and the Serious Incident Framework (2015) provide guidance for NHS Trusts on meeting expectations on recording, investigating and learning from deaths. Each mental health provider should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. Providers may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.

2.57. The National Guidance on Learning from Deaths is clear that mental health providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. This includes engaging the family on how they may wish to be involved in the investigation. Providers should adhere to the following guiding principles:

- bereaved families and carers should be treated as equal partners following a bereavement;
- bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment;
- bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one;
- bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison;
- bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations; and
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in delivering training for staff in supporting family and carer involvement where they want to. [38]

2.58. The guidance sets out the requirement that NHS providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken. This includes offering support, information and guidance, as well as bereavement advisors to help families and carers through the practical aspects following the death of a loved one, such as:

- arranging completion of all documentation, including medical certificates;
- the collection of personal belongings;
- post mortem advice and counselling;
- deaths referred to the coroner;
- emotional support, including counselling;
- collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
- details of the doctor's Medical Certificate of Case of Death (this is needed to register a death at the Registrar's Office).

The following should also be considered:

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings;
- further meetings with the organisations involved or support in liaising with other agencies such as the police. [41]

2.59. In many circumstances more than one organisation is involved in the care of any patient who dies. The Serious Incident Framework states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the IPCC who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. PPO Clinical reviews Guidance (2014) must be followed in these circumstances by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO. [39]

2.60. NHS England, led by the Chief Nursing Officer, will a develop guidance for bereaved families and carers. This will support standards already set for local services, including the Serious Incident Framework, and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers. Bereavement can influence every aspect of well-being.

2.61. Public Health England published a suite of guidance earlier this year to advise local areas, including mental health services, on providing effective suicide bereavement services. This suite of guidance is in addition to the Help is at Hand suicide bereavement guide which is funded by the Department of Health and Public Health England. [41]

2.62. Many of the issues raised are longstanding and entrenched problems which reach beyond the immediate context of deaths in police custody, and it is clear that significant work is required to propose long-term solutions. This is, therefore, the second strand of work that the Government has commissioned the Ministerial Council on Deaths in Custody to lead on considering. The Council will look into how Government as a whole can better support bereaved families, both in the immediate aftermath of a death in custody and throughout the inquest process. [40]

Communications[11]

2.63. Transparency and accountability have been at the heart of policing reforms since 2010. The police are required by law to refer all deaths or serious injuries that follow direct or indirect contact with the police and where that contact may, directly or indirectly, have contributed to the death or serious injury to the IPCC.[12] Police forces must make this mandatory referral without delay and, in any case, not later than the end of the day after the day it becomes clear that it is a matter that must be referred. The IPCC annually produces a report on deaths in or following police custody in England and Wales and these are recognised as official statistics. The most recent report was published in July and covers deaths that occurred between 1 April 2016 and 31 March 2017. [46]

2.64. PCCs also have statutory duties to publish certain information about their priorities, spend, staffing, decision-making and policies of their offices.[13] This is complemented by other published information about the legitimacy, efficiency and effectiveness of individual forces such as reports by the independent inspectorate HMICFRS and data held on Police.UK to assist the public in holding PCCs to account. The Government legislated in 2014 so that the IPCC can make and publish learning recommendations, and require the police or other recipient to publish their response, along with an action plan. The Government also legislated in 2017 to strengthen the requirement for PCCs to respond to HMICFRS reports. Collectively, these mechanisms provide necessary transparency and accountability to the system. [53]

2.65. In April 2013, the IPCC and police chiefs updated their media protocol[14] which sets out the roles of the police service and the IPCC for communication with the media and public in IPCC independent and managed investigations. This is to ensure public confidence in the investigation and in the police complaints system as a whole. Both the protocol and the Government recognise that whilst silence is not an option, it is important to remember that, in the early stages of an investigation, the information which is available is likely to be incomplete and/or unverified. It is the IPCC, not the police, who will comment or provide information directly relating to its investigation. The police are responsible for some communications which are connected to the IPCC's investigation including the reason why something has been referred to the IPCC and other matters impacting on local people or the wider public interest. The College of Policing provides guidance to the police on media handling. [50, 51]

Investigations

2.66. The role of the IPCC is crucial in a system of police scrutiny and complaints that functions effectively and commands public confidence. There is a clear need for a demonstrably independent body to oversee the police complaints system and investigate the most serious and sensitive cases involving the police.

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[11] Recommendation 54 is addressed in the *learning* section.

[12] A deaths or serious injuries matter means any circumstances (unless subject to a complaint or a conduct matter) in, or as a result of which, a person has died or sustained serious injury, and: i) At the time of death or serious injury the person had been arrested by a person serving with the police and had not been released or was otherwise detained; or ii) At or before the time of death or serious injury the person had contact of any kind – whether direct or indirect – with a person serving with the police and there is an indication that the contact may have caused – whether directly or indirectly – or contributed to the death or serious injury.

[13] Guidelines for PCCs on publishing information is available at https://www.gov.uk/government/publications/publishing-information-in-a-transparent-way

[14] Available at https://www.ipcc.gov.uk/sites/default/files/Documents/guidelines_reports/ipcc_acpo_media_protocol.pdf

2.67. The Government is building on the major IPCC change programme (announced in 2013) to ensure that the IPCC has the capacity, funding and powers it needs to investigate all serious and sensitive matters involving the police. Additional resource has enabled a five-fold increase in the number of independent investigations it opens each year compared to 2013/14. Reforms in the Policing and Crime Act 2017, when implemented, will increase the IPCC's powers. For example, the IPCC will be provided with a new power of initiative, allowing it to initiate its own investigations without the need for a referral from a police force. It will also be provided with a power to reopen a case that it has previously investigated, without having its original findings quashed at Judicial Review, where there are compelling reasons for doing so. This removes a layer of unnecessary bureaucracy which causes delay. The Government is also replacing 'managed' and 'supervised' investigations with a new system of directed investigations. This will ensure that, where a serious or sensitive investigation does require police input, the IPCC have a higher degree of control.

2.68. Further measures in the Policing and Crime Act 2017 fundamentally reform the governance arrangements of the IPCC, which will be renamed as the Independent Office for Police Conduct (IOPC) in January 2018. The existing Commission structure is being replaced with a new single head, the Director General, who will have ultimate responsibility for investigative decisions. The first Director General of the new IOPC was confirmed on 20 October 2017. As with the current Commissioners, the law stipulates that the post of Director General is not open to anyone who has previously served with the police. Importantly, the new Director General will also have the statutory power to determine which roles within the IOPC are barred to former police officers. Corporate governance will be provided by a unitary board consisting of a majority of non-executives, appointed by the Home Secretary.

2.69. In advance of implementation of these reforms, the Government is encouraging the IPCC to build on improvements to performance and to increase transparency and accountability.

2.70. It is essential that police officers provide a full and clear account as part of investigations into deaths and serious incidents, in line with the professional duties of police officers as witnesses. In the 2015 Government Consultation response to Improving Police Integrity, the Government set out proposals to address circumstances where police witnesses refuse to cooperate with investigations into serious and sensitive cases to encourage greater cooperation with investigations. The development of the legislation intends to ensure appropriate cooperation from police witnesses and to clarify the professional responsibilities and expectations from professional witnesses through a Duty of Cooperation with IPCC investigations. This development is ongoing and the Government expects this to be introduced in 2018, as part of wider reforms to overhaul the police complaints and disciplinary systems. [64, 65]

2.71. The Government is clear that officers should not confer when accounting for their actions following an incident. The NPCC supports this position. There are a number of means of increasing confidence in the witness statements officers provide, including supervision of officers, filming the post incident process and separation of officers. The Government is considering the IPCC's revised draft statutory guidance on best evidence in death and serious injury matters in light of recent incidents and ongoing work by the College of Policing to produce new post incident guidelines for death and serious injury cases, and will reach a decision in due course. [63]

2.72. The police are required by law to take all appropriate steps to obtain and preserve relevant evidence at the scene when there is a death or serious injury in police custody, as they would at the start of any investigation. The Investigation Authorised Professional Practice

produced by the College of Policing sets general standards for the conduct of investigations, and the Detention and Custody Authorised Professional Practice sets standards for responding to a death or serious injury in custody, including responsibility for securing evidence until such time as the IPCC takes over the investigation. CCTV use, coverage and maintenance – including securing footage of incidents - is also addressed in the APP. Disciplinary matters arising from the nature in which the duty to obtain and preserve evidence is discharged by individual police officers and staff is ultimately a matter for chief officers as the appropriate authority for disciplinary proceedings. Failure to carry out this duty properly may lead to disciplinary proceedings, and the IPCC has the power to investigate such failings as potential misconduct. The Government will implement provisions in the Policing and Crime Act 2017 to ensure that all investigations into disciplinary allegations against chief officers are undertaken by the IPCC or, in future, the IOPC. [46, 60, 61]

2.73. Body Worn Video (BWV) has the potential to be a powerful tool to help the police be more transparent, accountable, effective and efficient; however, more work is needed to understand how best to realise these potential benefits. Most forces in England and Wales use BWV to some extent; the decision to procure and deploy BWV is a matter for PCCs and chief officers. As of January 2017, 60,394 BWV cameras have been deployed or are planned to be deployed across police forces in England and Wales, and the Metropolitan Police Service is deploying around 22,000 cameras. The College of Policing published operational guidance for BWV in July 2014. [62]

2.74. In terms of independent investigations of deaths on NHS premises, the Healthcare Safety Investigation Branch (HSIB) was set up under Secretary of State directions as an organisational branch of NHS Improvement and has been operational since 1 April 2017. The HSIB will investigate certain serious incidents and risks to patient safety which have relevance for the system as a whole, and provide recommendations with the sole purpose of learning and not to apportion blame. HSIB's remit does not include a duty to investigate each incident that occurs, or incidents of a specific type. HSIB has the autonomy to set its own criteria to determine which incidents it will investigate, which can be broadly characterised as incidents with widespread significance for the system as a whole and that have the potential for system-wide learning. The HSIB does not replace any existing procedures, such as the NHS England Serious Incident Framework (SIF), for investigating individual incidents or accidents that demonstrate risks to patient safety, including Article 2 compliant incidents. [67]

2.75. In the Queen's Speech of June 2017, the Government committed to publishing a Bill in draft that will seek to legislate for an independent Health Service Safety Investigations Body (HSSIB). It is intended that the new body will take the place of the HSIB and will perform a similar function with respect to investigating serious incidents with relevance for system-wide learning. [67]

2.76. The Crown Prosecution Service (CPS) is the principal prosecuting authority in England and Wales, acting independently in criminal cases investigated by the police, the IPCC and others. When a person dies in police custody, and it appears that the death may have been caused by a criminal offence, the CPS may be asked by the investigating body for advice on whether a criminal investigation is warranted. If there is an investigation, the two bodies will work closely, for example to identify lines of enquiry to be followed. When the investigation is complete, and if the investigators believe an offence might have been committed, they will ask the CPS to decide whether there should be a prosecution. This is known as a charging decision. The decision to prosecute will only be made where the prosecutor is satisfied that there is sufficient evidence to give a realistic prospect of conviction, and that prosecution would be in the public interest.

2.77. Cases involving a death in custody are amongst the most serious and evidentially complex of all cases referred to the CPS. For this reason, only specially accredited prosecutors can deal with cases of this nature. Substantial changes were made to the way in which these cases were dealt with following the Attorney General's Review which was published in 2003. More recently, following a joint review of deaths in custody cases by the CPS and the IPCC, there have been further improvements made to address some of the issues raised in the Independent Review, including updating the information that is provided to bereaved families in deaths in custody cases. [70]

Coroners and Inquests

2.78. Following a death in police custody, the deceased's family and wider public as well as the police must be given answers and, where appropriate, lessons learned. The coroner's inquest is the forum in which this should happen, and it is essential that it is done effectively.

2.79. Inquests are intended to be inquisitorial, and so should not be adversarial. Despite this, as Dame Elish highlights, inquests currently involve legal representation for interested persons. The Government is committed to simplifying the system so that legal representation is not necessary in all cases, and will investigate how we can meet this ambition and take this forward over the coming months.

2.80. The Government recognises that in some circumstances, legal advice and representation may be necessary. This is why we have protected legal aid for advice in the lead up to, and during inquest hearings. The Government has also protected representation for the families at the inquest hearings through the Exceptional Case Funding scheme. In deciding whether to award legal aid, the Director of Legal Aid Casework must have regard to Article 2 ECHR ('the right to life'), and has the discretion to waive the means test. [33]

2.81. However, as Dame Elish's report indicates, the Exceptional Case Funding route to legal aid in inquests, and in particular the means testing involved, can be complex and intrusive. As a first step towards addressing these concerns and ensuring the bereaved can have confidence in these arrangements, the Lord Chancellor will review the existing guidance so that it is clear that the starting presumption is that legal aid should be awarded for representation of the bereaved at an inquest following the non-natural death or suicide of a person detained by police or in prison, subject to the overarching discretion of the Director of Legal Aid Casework. [33]

2.82. As part of this, it will also be made clear that in exercising the discretion to disregard the means test, consideration should be given to the distress and anxiety caused to families of the bereaved in having to fill out complex forms to establish financial means following the death of a loved one. [33]

2.83. We will complete this work by the end of this year, and ensure we are taking steps so that the bereaved are fully aware of their rights under this guidance in parallel. [33]

2.84. As a next step, the Lord Chancellor will consider the issue of publicly-funded legal advice and representation at inquests, in particular the application of the means test in these cases, as part of the upcoming post-implementation reviews of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, due to be published next year. [33]

2.85. In addition, we believe we can go further towards a non-adversarial inquest system which is better for all involved. The Lord Chancellor will also consider the following, to the same timescale as the legal aid review, to meet the challenge of making inquests less adversarial

and reduce the number of lawyers who attend without compromising fairness with the aim of making inquests more sympathetic to the needs of the bereaved.

2.86. We will consider the scope for reducing the number of legal representatives where interests are essentially the same and reassess cases where the Government instructs lawyers to see whether there are any parallels with those tribunal cases where the Government does not instruct lawyers as a matter of course (as well as the MoD practice of restricting when lawyers are instructed at some inquests into the death of service personnel). We will also consider whether changing institutional behaviours early on in the process after the death, such as an early apology, could assist in making an adversarial process less likely and whether there could be greater use of 'position statements' where public authorities admit failings or accept that improvements to their service could have avoided a death. We will discuss and work closely with the police and other relevant public authorities on both these areas of reform.

2.87. We will engage with the Solicitors Regulation Authority and Bar Standards Board to see what they might be able to do to improve the way lawyers conduct their representation in inquests and we will explore whether a system of accrediting lawyers to act in coroner cases could be established.

2.88. We will engage with the Chief Coroner on training coroners in "court craft", to have more confidence in "holding the ring", controlling the lawyers and keeping questions relevant. We will also consider extending support services for coroner's inquests to all coroner's courts so that bereaved families have access to practical and emotional support when they attend inquests, and we will consider providing more simplified information for those attending particular inquests over and above the MoJ *Guide to Coroner Services*. [76]

2.89. The issue of the effectiveness of the inquest process and the role of bereaved families must not be detached from the issue of funding for families and family support (discussed above). The inquest process is; therefore, the third strand that the Government has commissioned the Ministerial Council on Deaths in Custody to consider as part of its programme of work. [72, 73, 74, 75]

Accountability

2.90. Accountability is fundamental to the British model of policing by consent. The Government is continuing to overhaul the police complaints and disciplinary systems, seeking to ensure that, where misconduct is found, the systems provide a transparent and robust mechanism for holding police officers to account, particularly in the most serious cases of misconduct. [77]

2.91. The Police (Conduct) Regulations 2012 set out the professional standards by which all police officers are expected to abide. These have been reinforced by the statutory Code of Ethics, published by the College of Policing in 2014. These regulations set out the procedure to be followed at misconduct hearings, including Regulation 30 which relates to the attendance and role of a complainant or interested person at misconduct proceedings. This sets out the right of an interested person to attend such proceedings, including the relatives of persons whose death is alleged to result from the conduct of the concerned officer. This includes the opportunity to put questions to the officer concerned at the Chair's discretion. Since 2015 it has been mandatory to hold misconduct hearings in public, unless there are compelling reasons not to, which has improved the overall transparency of the misconduct process. The 2012 regulations provide a clear role for families, along with the legislative framework of the Police Reform Act 2002, setting out how information should be provided to complainants and relatives during investigations and any action taken subsequently. [82]

2.92. The College of Policing published its Guidance in Outcomes in Police Misconduct Proceedings in October 2017,[15] which provides guidance to the person chairing misconduct proceedings in determining appropriate findings and sanctions. The introduction of independent Legally Qualified Chairs for misconduct proceedings has introduced greater independence in decision making in such proceedings. The role of Legally Qualified Chairs will be further strengthened by providing for the chairpersons to have a clearer, more independent role in the convening and direction of misconduct hearings delivered through reforms to the regulations. The Government also intends to legislate to further increase transparency following the outcome of misconduct proceedings for the full determinations of misconduct hearing panels to be published in the future, bringing policing into line with other professions. [83]

2.93. Provisions in the Policing and Crime Act 2017 will be implemented later this year to extend the disciplinary system to former officers so that, even where an officer has left the force, an investigation and subsequent disciplinary proceedings can continue until their conclusion. This will apply in the following circumstances:

- if an officer resigns or retires from a force whilst subject to an investigation or disciplinary proceedings.
- where a serious allegation amounting to Gross Misconduct is received within 12 months of an officer leaving a force, in relation to conduct whilst that officer was serving and which could have led to dismissal, it will be investigated and subject to the disciplinary process.

2.94. The Government has also legislated to allow for disciplinary proceedings to be brought in exceptional circumstances regardless of when the matters come to light in the future. These officers will be held to account in cases involving the most serious acts of wrongdoing which lead to serious damage to public confidence irrespective of when the matter comes to light.

2.95. The Policing and Crime Act 2017 will allow the publication of a statutory Police Barred List of officers, special constables and staff who have been dismissed from the force and barred from policing. The relevant provisions will be implemented later this year. The information will be shared with police forces and other law enforcement bodies and recruiting authorities will be under a duty to consult the list before appointing individuals. This will include a police advisory list for vetting purposes covering people who leave but are subject to investigation or ongoing disciplinary action, enabling future employers to be aware and make informed decisions about recruitment.

Training

2.96. As set out in the preceding sections on *restraint* and *custody environment*, there is a body of legislation, standards and guidance that set out detailed parameters for the use of the power of detention, and best practice in delivering police custody services. This includes, but is not limited to, PACE and its Codes of Practice as well as the Detention and Custody Authorised Professional Practice and supporting curriculum issued by the College of Policing, all of which are reviewed and updated on a regular basis as new learning emerges and which inform the development and delivery of training packages.[16] [92]

2.97. Dame Elish's report reiterates that intoxication can be an exacerbating factor in medical emergencies arising in police custody, especially in cases where the suspect is aggravated

[15] http://www.college.police.uk/News/College-news/Pages/Guidance-on-misconduct-outcomes.aspx
[16] Recommendation 85 is addressed in the *custody environment* section.

and restraint is used. This knowledge must remain at the forefront of police training and practice and the medical implications of restraint for intoxicated individuals must continue to be regularly reviewed by leading healthcare professionals. The Detention and Custody APP sets out standards for monitoring and supervising individuals who are under the influence of alcohol if they are held in police custody; this includes putting in place an appropriate risk assessment and care plan and guidance on seeking medical assistance. In addition, the College of Policing has begun developing guidelines on 'Safer Resolution', in order to support officers and staff to manage conflict without force through containment, including use of de-escalation techniques, which it is anticipated will be published in 2018. [84, 86]

2.98. The College of Policing published Mental Health APP in 2016 which highlights the actions and behaviours that may help the police address the needs of mentally vulnerable individuals. The APP is complemented by the Mental Health and Learning Disabilities Trainer Guide. These products address themes, such as skills for managing people at the point of contact through the use of effective communication, highlighted in a number of national reports that were written in response to ongoing issues in the care and management of people with mental ill health and vulnerabilities and those with learning disabilities or difficulties.[17] In addition, the NPCC's National Strategy for Police Custody sets out principles of unified standards of training, and the NPCC's National Custody Forum is currently building an understanding of what training is currently in place across the 43 police forces to inform options for improving consistency and quality, where needed. The National Strategy for Police Custody stresses the importance of taking full account of detainee's vulnerability and the need to work collaboratively with partner agencies to divert vulnerable people from the justice system wherever appropriate and possible. [86, 87, 91, 96, 97]

2.99. The Detention and Custody APP includes guidance on releasing detainees from custody and the pre-release risk assessment process, setting out options open to the police for supporting vulnerable detainees on release. Guidance is also provided on the risk of self harm and suicide after release, in the event that it becomes apparent through pre-release risk assessment that a detainee is extremely vulnerable. [89]

2.100. The College of Policing has also developed unconscious bias training as part of the wider training requirement for officers in respect of stop and search which aims to raise awareness of personal biases and anticipate how these may affect decision making. [88]

2.101. Where children are charged and denied bail, it is essential that the police understand that secure local authority accommodation should only be requested for those rare cases where the child poses a risk of serious harm to the public, and that in all other cases only non-secure accommodation is requested. This is among the aims of the Concordat on Children in Custody, which has been launched alongside publication of Dame Elish's review and to which all police forces and over half of all local authorities in England have signed up.[18] [90]

2.102. The Detention and Custody APP provides guidance on the particular requirements of female detainees, and highlights the need for a different and distinct approach taking into account a variety of factors, such as physical and medical welfare needs, mental health, domestic violence and abuse issues and conditions under which women are searched. This includes guidance in relation to risk assessment, as well as sanitary facilities, exercise and clothing. [93]

[17] https://www.app.college.police.uk/app-content/mental-health/introduction-and-strategic-considerations/
[18] See also *custody environment* section.

2.103. Dame Elish's report rightly places an emphasis on the experience of families and the value of incorporating their perspective in various aspects of training and awareness; not only for the police, but for coroners, the CPS and the IPCC. The Government will work with INQUEST and others to explore how this is best achieved. [95]

Learning[19]

2.104. Dame Elish notes in her review that: "One of the key themes to emerge from this review is the failure to learn lessons." The Government recognises that the Ministerial Council on Deaths in Custody has a key role to play in driving change in this area, drawing on its cross-Government structure, expert membership and specialised Independent Advisory Panel to tackle multidisciplinary problems which cut across multiple agencies' responsibilities. The Ministerial Council on Deaths in Custody is jointly sponsored by the Ministry of Justice, the Department of Health and the Home Office. The Council consists of three tiers: Ministerial Board on Deaths in Custody; Independent Advisory Panel (IAP); and Practitioner and Stakeholder Group.

2.105. The Council's remit covers deaths which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act in hospital. The Ministerial Board is co-chaired by Ministers from the three departments responsible for institutions that detain individuals, and its purpose is to address the combined agenda of reducing deaths in custody. Membership of the Board includes operational leads, relevant regulatory and inspection bodies and charities, including charities that provide advice to bereaved people. The Government has given the Ministerial Board's co-chairs responsibility for considering Dame Elish's recommendations relating to healthcare in police custody, support for families and the inquest process. This will introduce necessary oversight and external challenge to ensure lessons are learnt.

2.106. The Government is determined to ensure the Council provides joint leadership across the custodial system to share best practice and to learn lessons to prevent future deaths in custody. In order to strengthen and reform the Council, the Government has increased the resources and refined the remit of the IAP and is working to better align the work of the Board and the IAP through a new annual process of collectively agreeing priorities. The Government will also review the membership of the Council to ensure the necessary organisations are represented to deliver on actions and provide challenge. [99]

2.107. The Government has asked the Ministerial Board to oversee progress in implementing the recommendations arising from Dame Elish's review. At the next meeting of the Board on 1 November, members will agree priorities for the year ahead. An outline work programme for the Ministerial Council is at Annex A. [54]

2.108. The Government, however, does not consider that a new and distinct Office for Article 2 Compliance is the most effective means of driving compliance with Article 2 of the European Convention on Human Rights (ECHR). Rather, it must be recognised that existing agencies have a role to play here and their collation and dissemination of learning in this area must be made more effective, rather than duplicating this function in a separate Office for Article 2 Compliance. Coroners, inspectorates, watchdogs (such as the IPCC) and the Ministerial Council on Deaths in Custody should work towards strengthening their collaboration in this regard, and the Government will lead conversations as to how this is best achieved. [100, 101]

[19] Recommendations 96 and 97 are addressed in the *training* section.

Statistics

2.109. From 1 April 2017, all police forces across England and Wales have commenced recording a broad range of use of force data including the reason force was used, injury data, the gender, ethnicity and perceived mental health of the individual, and the location and outcome of the incident. To date, more than 20 police forces have published their use of force data locally for the first time - something they will do on a quarterly basis hereafter. A subset of the use of force data collected by police forces will form part of the Home Office Annual Data Requirement from 2017/18. Home Office statisticians will review the data provided and publish the entire data series on GOV.UK in summer 2018. Selected data will also be analysed and published at aggregate level as official statistics which are likely to include, although not limited to, the type of force by age, gender, ethnicity, mental disability, reason for force, injuries to officers, injuries to subject, and the outcome of the incident. The publication of data on officers' use of force will introduce unprecedented transparency and accountability and provide insight into the challenges faced by the police as they perform their duties. In the longer term, it will also provide an evidence base to support the development of tactics, training and equipment to enhance the safety of all. The data being recorded and published by forces will be kept under constant review, including through a police-led Programme Board. [102, 105, 106]

2.110. While some police forces are already recording ethnicity data by 'Gypsy or Irish Traveller', under the Annual Data Requirement (ADR) the Home Office currently collects data on ethnicity (from police forces) in line with the ONS categories used in the 2001 census (16+1), which does not include 'Gypsy or Irish Traveller'. The Home Office is working with partners across the Criminal Justice System to determine how a change is best achieved to include the additional ONS categories of 'Gypsy or Irish Traveller' and 'Arab' used in the 2011 census. [108]

Research

2.111. It is essential that police equipment is subject to robust testing and monitoring. Conducted Energy Devices, of which TASER® is one form, provide a less lethal alternative to conventional weapons such as firearms. The Home Secretary follows a stringent authorisation process before approving less lethal weapons for use by the police, which includes extensive technical and medical evaluations, as well as operational trials. Only less lethal weaponry that has been authorised by the Home Secretary may be used by police forces in England and Wales. [110]

2.112. The police regularly review their guidance and training and continue to do so in the light of recent incidents. The Scientific Advisory Committee on the Medical Implications of Less Lethal Weapons (SACMILL – the Government's independent advisory medical committee), keeps its assessment of the medical implications of less lethal weapons, including TASER®, under review, including through consideration of available research. Statistics on the police use of TASER® are published regularly by the Government.[20] From summer 2018, and annually thereafter, the publication of data around police use of TASER® will be included as part of the broader set of use of force data which now forms part of the Home Office Annual Data Requirement. [110]

2.113. It is also important that police training and practice, especially around use of force and restraint in custody, is informed by the most up to date medical and scientific research from around the world. Under the auspices of its National Custody Forum, the NPCC has recently established a Health Working Group, bringing together leading experts and

[20] Available at https://www.gov.uk/government/collections/use-of-taser-statistics

practitioners from the NHS and policing. This group will seek to identify opportunities for increased international collaboration and to ensure that the latest international research is reflected in the work of the National Custody Forum and in wider policing practices. [109]

Annex A: Work Programme for the Ministerial Council on Deaths in Custody

Quarter	Action
Oct-Dec 2017	• Meeting of the Ministerial Board on 1 November. • Establishment of two Working Groups, with meetings of each held by the end of 2017 • Development of proposed work streams for addressing key issues. To include for example: **Healthcare in Police Custody** i. Identification of good practice in police custody healthcare across police forces in England and Wales; ii. Exploration of alternatives to the use of prolonged physical restraint against detainees, especially in the context of mental health crises; iii. Identification of opportunities in the Independent Review of the Mental Health Act 1983 to consider police powers (sections 135 and 136) under the Act. This should consider the legislation itself, including recent amendments made by the Policing and Crime Act 2017, and how well it works in practice i.e. the role of the police and how effectively they are supported by health and care services. **Inquests and Support for Families** i. Exploration of how coroners' inquests in Article 2 cases can become more independent of the police or other investigatory bodies; ii. Review guidance for coroners in respect of the treatment of bereaved families in coroners' inquests into Article 2 cases; iii. Consideration of appropriate levels of legal representation for all parties in coroners' inquests into deaths in police custody; iv. Scope options for improving immediate post-incident support and guidance for bereaved families, to help them through the traumatic and complex processes involved in a death in police custody.
Jan-Mar 2018	• Meeting of the Ministerial Board. • Working Groups to submit to the Ministerial Board: o Developed work streams for Board approval;

Jan-Mar 2018	○ Update on any relevant background /case studies/emerging findings; ○ Timetable for key deliverables in Q4.
Apr-Jun 2018	• Meeting of the Ministerial Board. • Working Groups to submit to the Ministerial Board: ○ Progress updates against agreed work streams, including how experiences of families of people who have died in police custody are incorporated into Working Groups and informing development of solutions; ○ Test emerging options with Board to enable preferred options to be finalised.
July-Sep 2018	• Meeting of the Ministerial Board. • Working Groups to develop proposal papers with impact assessment and cost/benefit analysis for consideration by the Board. • Ministerial co-Chairs to provide written update to the Prime Minister on Council's actions and next steps.