

Report of the Independent Review of Deaths and Serious Incidents in Police Custody

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Acknowledgments

This review looked at the wide range of circumstances around deaths and serious incidents in police custody and of suicides occurring shortly after release from police custody. The process involved examination of events from the initial restraint or other circumstances preceding the death, through the investigation and Inquest to the outcome of these formal investigative processes.

I am very grateful to the great many individuals and representatives of organisations who met me or provided information or submissions. I am particularly indebted to those who attended the many focus group meetings.

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Elish Angiolini
6 January 2017

Executive Summary

Executive Summary

Background

1. On 23 July 2015 the then Home Secretary, the Rt. Hon Theresa May MP announced a major review into deaths and serious incidents in police custody.
2. The review has looked at the major issues surrounding deaths and serious incidents in police custody. This included the events leading up to such incidents, as well as existing protocols and procedures designed to minimise the risks. It looked at the immediate aftermath of a death or serious incident, and the various investigations that ensue. Most importantly it examined how the families of the deceased are treated at every stage of the process.
3. It has also identified areas for improvement and developed recommendations to ensure humane institutional treatment when such incidents occur. There are several recommendations that will have to be considered by Government, the police, the Independent Police Complaints Commission (IPCC), the Crown Prosecution Service (CPS) and the Coroner as well as other agencies with an involvement in these issues. While acknowledging that it would not be possible to entirely eradicate deaths and serious incidents in police custody, these recommendations are, I believe, necessary in order to minimise as far as possible the risks of such incidents occurring in future. They will also ensure that when such incidents do occur, the procedures in place are efficient, effective, humane, and command public confidence.

Key findings

4. The creation of the **Independent Police Complaints Commission** (IPCC) was a result of many years of campaigning for an independent body to investigate police actions. Such a body was floated as far back as the 1981 Scarman Report.¹
5. There is still a view among many families of those who have died in custody and of campaigners, lawyers and police officers who spoke to this review that the IPCC does not always feel truly independent of the police or of police culture. This is in part because of the numbers of former police officers employed by the IPCC. If an independent investigative body is to succeed, it must have the trust of families, and the full cooperation of police forces.

1 https://openlibrary.org/books/OL20761127M/The_Scarman_report

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6. **To ensure that the IPCC can achieve a mature and patent independence from the influence and culture of those it investigates, ex-police officers should be phased out as lead investigators within the IPCC. To the extent that the IPCC still consider this expertise is required, ex-police staff should act only as formal consultants or as a training source within and, more appropriately, outwith the organisation.**
 7. Cases involving a death or serious incident in police custody are likely to be among the most serious and complex cases the IPCC have to investigate. They clearly demand the highest priority in terms of resources and expertise of the organisation. Complexity and seriousness should not in itself be an excuse for unnecessarily long and protracted investigations.
 8. **The causes of delay and problems with the quality of investigation may be addressed by the creation of a specialist Deaths and Serious Injuries Unit within the IPCC and through a fundamental change in how such cases are investigated, supervised and resourced. The Unit should be staffed by senior and expert officers from a non-police background.**
 9. This report also considers the capacity of the IPCC to attend the scene of a police custody death in a timely fashion. The first hours following a death are crucial. What happens during that period can fundamentally set the shape and tone of an ensuing investigation because of the importance of evidence preservation and collection. Similarly, the family experience of the entire process may be coloured by the way they are treated in these first crucial hours.
 10. **The IPCC should therefore be resourced to ensure an experienced officer can attend as a matter of urgency at the scene. On arrival that officer should liaise with the Senior Police Officer in Charge and with the Coroner, direct early steps, act as an observer to ensure the integrity of the evidence and communicate with specialist officers from a new IPCC Deaths and Serious Injuries Unit as those officers make their way to the scene.**
 11. The extent to which restraint techniques contribute to deaths in custody and whether current training is fit for purpose is a crucial aspect of this report. This report argues that police practice must recognise that all restraint has the potential to cause death. Recognition must be given to the wider dangers posed by restraining someone in a heightened physical and mental state, where the individual's system can become rapidly and fatally overwhelmed. For example, positional asphyxia is a form of asphyxia which causes death when a person's position prevents them from breathing properly. It may occur during or following the use of certain restraint techniques, for example, in face down or prone restraint.

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12. Currently there is no consistency of training in restraint techniques across the 43 police forces in England and Wales. There should be mandatory and accredited national training for police officers in restraint techniques and supervision of vital signs during restraint, with appropriate refresher training for officers. There should be national consistency in approaches to the use of force. In addition, the ability to de-escalate circumstances which may lead to a physical or violent encounter should be paramount in the skills set of the individual officer.
 13. **National policing policy, practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk.**
 14. In all investigations it is important to capture, as soon as possible, the individual accounts of any eye witnesses or witnesses of fact, uninfluenced by the recollections or perceptions of others. In cases not involving the possibility of fault on the part of police officers the approach the police take with civilian witnesses following an incident will, so far as possible, be to keep witnesses apart, ensuring the account given to the police is the fresh individual recollection of that witness, uninfluenced by the recollections of other witnesses to the same event.
 15. Currently, the opportunity for police officers to confer with each other during a formal meeting occurs before the IPCC becomes involved and means that the police force to which the officers belong is the only body supervising and enforcing the immediate post-incident procedures.
 16. The appearance of, or opportunity for, collusion presented by these meetings can seriously undermine public confidence in the subsequent evidence of police officers. The longer those officers who are critical witnesses to the event remain together following the death, the greater the anxiety and suspicions by families and others that the evidence of individual officers has been inadvertently or deliberately fine tuned to accord with the evidence of their colleagues.
 17. The Police Federation members who spoke to this review stated that only matters of fact would be discussed at such meetings, not matters of belief, in order to ensure better quality and more accurate statements. They stated that the IPCC had no tolerance for any discrepancies in police statements.
 18. Even if conferral is not carried out with deliberate, dishonest intent, it can result in innocent contamination of accounts that is harmful to the integrity of evidence. Once officers have recorded their accounts the statements will form a central feature of the entire investigation and inquest process.

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19. **Other than for pressing operational reasons, police officers involved in a death in custody or serious incident, whether as principal officers or witnesses to the incident should not confer or speak to each other following that incident and prior to producing their initial accounts and statements about any matter concerning their individual recollections of the incident. This constraint should also include even seemingly minor details.**
 20. **As with civilian witnesses, all statements should be the honestly held recollection of the individual officer. The further roll out of body worn cameras for police officers and CCTV cameras in police vans, as well as the increasing availability of video recorded material from mobile phones should assist the accuracy of evidence retrieval in the future.**
 21. It has been a longstanding complaint of families of people who have died in police custody and of those who support them through the process that the various agencies within the criminal justice system have not delivered the rigorous and effective service expected of them.
 22. While the occurrence of a death in custody may cause great shock and concern by officers within the police force, families feel that very rapidly that shock is replaced with defensiveness.
 23. Given the estrangement from the police that families may feel in such cases the effectiveness of the responses of the IPCC, the Coroner and the Crown Prosecution Service (CPS) becomes critical to maintaining faith that the State will fulfil both its domestic law obligations and those under Articles 2 and 3 of the European Convention on Human Rights.
 24. Of eight prosecutions of police officers in connection with a death in custody in the last 15 years, all have ended with acquittals. These include prosecutions for murder and manslaughter. In fact, there has never been a successful prosecution for manslaughter in such cases, despite unlawful killing verdicts in Coroner's Inquests.
 25. Health and safety prosecutions in the context of a death at the hands of the state have, on occasion, been employed as an alternative to homicide charges in police shooting cases, most notably in the deaths of Jean Charles De Menezes and Anthony Grainger. Both these prosecutions were brought by the CPS, not the Health and Safety Executive (HSE), with the CPS deciding that there was insufficient evidence to support a homicide charge.²
 26. The issue of delays in IPCC investigations and CPS decision making is also of grave concern to families of the deceased and police officers who may be left in limbo for very substantial periods of time. Delays may be caused by a lack of early engagement with the CPS during the course of the IPCC investigation. Independence does not call for isolation and indeed isolation weakens the independence of the IPCC. Regular liaison allows each of the respective agencies to bring their own expertise and perspectives

2 http://www.cps.gov.uk/news/latest_news/103_09/

to the table and to make their own preparations and plan for the presentation of any evidence in the event of a prosecution. Delays in any one part of these processes can be reduced by a more coherent and consultative approach by all to the death from the earliest opportunity.

27. This is acknowledged by both organisations who have now put measures in place to encourage early and regular communications.
- 28. In order to progress investigations in a timely manner, and ensure that all agencies are working efficiently and effectively, it is critical for the IPCC, CPS and HSE to meet very early following a death in police custody to review the emerging evidence, and take an early view as to whether criminal charges including health and safety charges or corporate manslaughter might be a possibility, to discuss the nature of expert evidence that may be required, the lines of evidence to be explored and likely timescales. Further regular meetings should take place as the investigation progresses as required.**
29. The dignity and tenacity of the many families of those who have died in police custody is humbling. In many cases, with little support, resources or expertise, they have over many years had to make themselves experts in police procedures and practices as well as case law. They have also had to attend meetings with investigators and hearings before the courts, carry out their own investigations, ask probing and pertinent questions, represent themselves at the Inquest hearing and maintain pressure on the authorities, despite the personal and financial toll of their determination.
30. The involvement of families in the process should not be seen as a matter of being sympathetic or benevolent to bereaved relatives. Under Article 2 of the *European Convention on Human Rights* families of the deceased must be allowed to be involved in the investigation in a meaningful way.
31. The trauma that some families suffer in the wake of a death is exacerbated by the lengthy process that often follows. It is simply not possible for families to begin the grieving process or achieve closure when, in some cases, they may wait years for a resolution.
- 32. There is a need therefore for properly funded specialist bereavement counselling which can be offered to families from the outset, similar to that offered by the Homicide Service of Victim Support. For some families it may be too soon to want to speak about their experiences, but the offer of counselling should be on the table for the duration of the various investigations, and indeed well after their conclusions.**
33. It became clear during the review that one of the main factors that motivates families is a desire that no one else in future should have to endure what their loved one or they have experienced. It is for this reason that the accumulated knowledge and experience of families should be harnessed by the various agencies of the state. These agencies should consider how best to involve the families in training and awareness exercises.

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34. The need for an independent investigation where there has been a sudden or unexplained death is enshrined in English law by the Coroners and Justice Act 2009; the Coroners (Investigations) Regulations 2013; and the Coroners (Inquests) Rules 2013. Inquests are usually held by the Coroner without a jury, but the 2009 Act states that a jury should be used if the deceased “died while in custody or otherwise in state detention” and the cause of death was violent, unnatural or unknown; the death resulted from the act or omission of a police officer; or the death was caused by a notifiable accident, poisoning or disease.
 35. In addition, Article 2 of the European Convention on Human Rights imposes a procedural obligation on the UK to conduct an effective, impartial, independent and prompt investigation into deaths for which the State might be responsible. This Article also forms one of the Convention rights incorporated in the Human Rights Act 1998.
 36. Coroners are appointed by and are wholly dependent on Local Authorities for their resources, and in the absence of a National Coroner Service, there is little consistency in the way in which the Coroner is resourced or supported for the purposes of their enquiries, nor at the Inquest hearing. Most Coroners’ offices are staffed, among others, by police officers seconded from the local force as investigating officers as well as former or seconded civilian employees of the local force.
 37. The overall picture from a number of those who participated in the review meetings and focus groups is one of a coronial system under great pressure of resources, is ‘ad hoc’ and largely dependent on a ‘grace and favour’ relationship with other agencies.
This report therefore recommends the establishment of an independent National Coroner Service to address the inconsistencies and fundamental shortcomings in the current local authority administered structure and the current challenges faced by Coroners in devoting resources and time to their approach to complex deaths including deaths in custody before and during the Inquest hearings.
 38. As soon as the Coroner is made aware of a death he or she assumes jurisdiction over the body. The Coroners (Investigations) Regulations 2013 state that the immediate family, and other interested persons, should be informed of the date, time and location of the post-mortem examination.
 39. In addition, the regulations state that families are entitled to representation at a post-mortem examination by a medical practitioner. However, this does not always happen. The ability to request a second post-mortem examination is often not fully understood or exercised by families.
 40. A grieving family may simply not be in a position to make quick, informed decisions about the best way to engage with post-mortems. Some families were only informed of a death after the post-mortem had taken place, and others who were informed of the death were unaware that the post-mortem was taking place. The Coroner should provide information to families about the post-mortem examination before it takes place – including the time and location of the examination, and their right to have a representative present, and all other associated rights.

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41. The experience of attending at the scene of the death and then waiting for and attending an inquest is deeply traumatic for families. In many cases the grief and trauma of losing a loved one is compounded by the confusion and bewilderment of the unfamiliar, formal and sometimes adversarial hostile atmosphere of the Coroner's court. This is also exacerbated by the often significant delays in waiting for the Inquest to be held. Without help and support the inquest may be a very intimidating experience.
 42. The physical environment of the court can itself be a major factor in how families perceive the process. Most Coroners do not have their own courts. Not all courts are equipped to give space to families when they need moments of privacy.
 43. The most significant and visible example of the imbalance that can exist in the coronial process is that of the inequality of arms that accompanies many inquests. Currently, the family of the deceased has no automatic right to funding for legal representation despite various branches of the state each having separate and very senior legal representation throughout the process.
 44. The reason cited to explain why families have no automatic right to state funding for legal representation is based on the belief that inquests are inquisitorial processes, designed to discover the facts of the case, and not apportion blame. The reality is that Inquest hearings into death in police custody are almost always adversarial in character. This has been the unanimous opinion of Coroners, lawyers and families who have given evidence to this review. **For the state to fulfil its legal obligations of allowing effective participation of families in the process that is meaningful and not "empty and rhetorical" there should be access for the immediate family to free, non-means tested legal advice, assistance and representation immediately following the death and throughout the Inquest hearing.**
 45. One of the key themes to emerge from this review is the failure to learn lessons and to properly consider and implement recommendations and advice from the learning materials produced by a range of interested organisations and from previous reports and studies.
 46. A national body should be established to oversee the national **dissemination of learning**, and also monitor adherence to Article 2 obligations. It should be capable of bringing fragmented learning together, and ensuring that recommendations from various reviews, papers and Inquests are followed-up and implemented. It should also be able to assist inspection and monitoring bodies in their important work.
 47. **The Government should therefore consider establishing a national 'Office for Article 2 Compliance'. It would be accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and monitoring the consistency of its application at a national level. It should report publicly on the accumulated learning, and compliance arising from Inquest outcomes and recommendations. It should provide a route for bereaved families and community groups to voice their concerns and help provide a mandate for its work.**

Guarding the Vulnerable

48. During the 11 years 2004/05 – 2014/15, 82% of people who died in or following police custody had some link to **alcohol and/or drugs**. Overall, 49% of those who died had alcohol and/or drug related factors identified specifically as a cause of death in a post-mortem examination.
49. These figures highlight that drugs and alcohol remain a significant factor in deaths in police custody, and indicates that this is as much a public health issue as a policing issue. The adherence to policies designed to protect the health and safety of detainees is fundamental. The need to effectively implement observation regimes for severely intoxicated detainees is therefore of manifest importance.
50. The viability of drying-out centres as a potential alternative to either police custody or Accident and Emergency (A&E) departments for those under the influence of drink and/or drugs and who require specialist supervision needs to be reconsidered. This report recommends that the Government should consider piloting a centre or centres in large urban areas where it is most likely to be cost-effective, and linking such centres to existing A&E departments. An alternative would be the fundamental redesign of A&E departments to take into account this challenging situation.
51. Mental healthcare facilities may refuse to accept people detained under section 136 of the Mental Health Act 1983 if they are intoxicated. Clinical staff are subjected to the problem of violent and drunken behaviour on a regular basis. However, the refusal to accept people who may be at their most vulnerable and suffering from mental ill health, exacerbated by intoxication, poses great danger to the life of these individuals. Without proper medical assessment it is not always obvious if there is a serious medical condition over and above the dangers posed by severe intoxication.
52. An NHS initiative therefore is required at the national level to examine whether to prohibit the refusal of access to A&E or to health-based places of safety on the basis of severe intoxication. It should also consider the redesign of A&E facilities to allow for safe areas, to protect the safety of other patients and staff from the disturbing or abusive behaviour of those suffering from intoxication but whose lives may also be in grave danger.
53. This report explores the link between mental health and deaths in police custody. Much of 21st Century police work involves dealing with mental health issues. IPCC statistics on deaths in police custody show a significant proportion of deaths involve people with mental health needs. Figures published for 2015/16 show that 7 out of 14 people who died that year in police custody had a mental health issue.

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54. It is recommended that there should be national, comprehensive, quality assured mental health training for all officers in front-line or custody roles. Training should be interactive and should involve mental health users to help break down potential fears and assumptions of detainees with mental ill health. This report also discusses the use of Section 136 of the Mental Health Act 1983, and supports the urgent phasing out of police stations as a designated place of safety.
 55. Successful local mental health policing pilots and initiatives, particularly street triage and liaison and diversion schemes should be funded on a sustainable basis for national roll out so that, as far as possible, those in mental health need are dealt with through medical and community based pathways and not through police detention.
 56. The Government has acknowledged that there is ‘significant overrepresentation of Black, Asian and minority ethnic (BAME) individuals in the criminal justice system’ and consequently, in January 2016, announced that David Lammy MP would lead a review to investigate evidence of possible bias against Black defendants and other ethnic minorities. The interim findings published in November 2016 found disproportionality within the legal system and that “arrest rates are generally higher for the BAME population in comparison to the White population”.
 57. There is evidence of disproportionate deaths of BAME people in restraint related deaths. Any death involving a BAME victim who died following the use of force has the capacity to provoke community disquiet leading to a lack of public confidence and trust in the justice system. This can be exacerbated if people are not seen to be held to account, or if the misconduct process is opaque.
 58. People who find themselves in police custody can be highly vulnerable due to a variety of circumstances including pre-existing mental health difficulties or because of the circumstances of the arrest. People arrested for crimes relating to sexual offences or domestic violence, for example, may fall into this category due to the shame and stigma of arrest for such offences.
 59. There has been very substantial progress made in reducing self-inflicted deaths within police stations. For the years 1998/99 to 2015/16 there were 45 self-inflicted deaths in police custody, of which 34 were hangings. The IPCC reported a reduction from 14 hangings in 1998/99 to generally 1-3 a year in the following years until 2008/09. Since then, there has been one self-inflicted death in a police cell, in 2014/15, and, sadly, another report of such a death in December 2016.
 60. However, the number of apparently self-inflicted deaths by a detainee within two days of their release from police contact is high. According to IPCC statistics there were 60 such deaths recorded in 2015/16.

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61. College of Policing guidance on detention and custody and force training should include guidelines for pre-release risk assessment, setting out specific practical steps that should be taken to provide support and protection for those at risk of self-harm on release. Custody inspections should continue to focus on the use of liaison and diversion schemes, pre-release risk assessment, and actions taken on release, as part of the inspection regimes of police forces.
 62. Children and young people who come into contact with the police are often among the most vulnerable in society. The police must make protecting the safety and welfare of children and young people in their care a 'primary consideration'. The United Nations Convention on the Rights of the Child clearly sets out that criminal justice services must consider and prioritise the best interests of the child.
 63. There is a very welcome downward trend in child arrests. According to Home Office statistics the number of 10 to 17 year olds arrested in England and Wales has decreased by two thirds since 2009/10 (88,577 in 2015/16 compared with 241,459 in 2009/10, a 63% reduction).
 64. However, there is more work to do. Children and young people should be held in police custody only as a last resort, and where charged and refused bail they should be moved to appropriate Local Authority accommodation as swiftly as possible.
 65. Local Authorities should ensure that they have reasonable systems in place to guarantee that all police requests for accommodation, whether secure or non-secure, are accepted and police training and inspection should focus on utilising non-secure accommodation for children other than in exceptional circumstances, where children pose a risk of harm to the public.
 - 66. This report also argues that the use of police custody for children detained under section 136 of the Mental Health Act 1983 should be brought to an end with all NHS Trusts required to make sufficient provision of health-based places of safety to meet this requirement.**
 67. This report stresses the need for a cautious, informed and empathetic approach to detainees. It may not always be apparent whether a detainee is vulnerable or has unique needs that have to be addressed. Sometimes the disability may not be apparent, and the actions of a vulnerable person might be misinterpreted by police. This can result in conflict and the use of force. The police require the necessary training and experience to identify the various conditions and circumstances that render individuals vulnerable while in custody and be able to respond appropriately.
 68. This report considers the needs of vulnerable people who may be particularly affected by detention in police custody such as those with social communication and perception disorders such as Autism and learning disabilities and people suffering from epilepsy.

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69. Women form only a small part of the overall number of people who will find themselves in police custody. They are also more likely to be experiencing custody for the first time than men. As a result, they may be unfamiliar with the custody environment and therefore more vulnerable. Police training should address the particular stressors that affect women detainees and young women in particular. Officers should understand the additional impact of these stressors upon women with mental health difficulties and the importance of access to healthcare. The vulnerability of transgender individuals also needs to be addressed with great care and sensitivity.
 70. Custody procedures should also be developed to lessen the impact of separation of mothers from young children. For example, supervised telephone contact around childcare issues should be prioritised and visits with children and their carers facilitated for longer detentions unless the nature of the alleged crime or the ongoing investigation prevents this. There should be monitoring of the extent to which police bail decisions take account of women's caring roles and the effects on the likelihood of absconding.
 71. Whenever a death or serious incident occurs in an NHS setting following police contact, or where someone suffering a mental health crisis has come into contact with the police because of failures in mental healthcare services, there may be a need for an NHS investigation.
 72. There is currently no formal independent investigatory body for deaths in healthcare facilities, including NHS hospitals and mental health detention settings. Whereas any police action relating to a death or serious incident can be investigated by the IPCC, there is no equivalent body looking at the actions of healthcare workers in the same circumstances. Deaths of patients detained under the Mental Health Act 1983 must be referred to the Care Quality Commission but it is the healthcare provider's responsibility to ensure that there is an appropriate investigation, and what form that investigation takes.
 73. This report argues that independent investigations should always be held for all Article 2 related cases on NHS premises where there has been police involvement, or where someone died after contact with the police. In addition, the Government should consider whether there is a need for a formal independent investigatory body for NHS Trusts in England and Wales.
 74. Joint working between the police and other agencies on the care and welfare of vulnerable people must run smoothly and efficiently in order to minimise future deaths in custody. There have been occasions where failures in joint working have contributed towards deaths arising from custody, a critical issue that has been highlighted by both juries and Coroners at inquests.

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75. There have also been concerns expressed about poor quality medical care within the police custody environment. These concerns have attracted criticism of police employed Forensic Medical Examiners (FME), and also of nurses and other healthcare professionals operating in the custody environment. Failures arise in the quality of medical care and lack of effective instructions to, and communication with, custody staff.
 76. There are also concerns about the inadequacies of some custody detention officers employed by private companies. This includes the way in which civilian Custody Detention Officers (CDO) perform their duties, as well as training provisions and management lines between CDOs and police officers, particularly custody sergeants.
 77. There has been advanced discussion and planning for medical services within police stations to be brought within the NHS, in the same way they are in prisons. This would allow for a consistency of approach across the forces in England, and also provide for minimum standards for medical staff within the police station, something that is potentially undermined by the current fragmented approach. Critically, it would also allow for rapid access to NHS medical records which would alert the doctor to underlying life threatening conditions that were not patent or volunteered by the detainee, such as diabetes or epilepsy. **NHS commissioning of healthcare in police custody was due to have commenced in April 2016, but was halted by the Government earlier in the year. This report strongly recommends that this policy is reinstated and implemented.**
 78. The role of Independent Custody Visitors needs to be recognised and valued for the vital role they play in helping to safeguard conditions within police custody. This means that they should have all necessary support required to collate and disseminate learning, and see it acted upon.
 79. Ultimately, the main focus of the police and other agencies should always be to divert the most vulnerable people from police custody at the earliest stage possible (depending of course on the severity of the crime for which they have been detained, and the record of the detainee). The Government has a responsibility to ensure that the police and healthcare providers are properly resourced to do so and that the most effective disposals become more readily available.
 80. The vast majority of police officers conduct themselves with integrity at all times, often during very challenging conditions. However, where things do go wrong, the public have a right to expect that the actions of police officers are properly investigated, and where there have been failings on the part of the police, that these will be dealt with appropriately.
 81. The opinion of families who spoke to the review is that police officers are seen to be above the law. Suspensions are rare in this context. The IPCC is often slow to instigate conduct investigations and disciplinary procedures are often opaque.

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82. This report argues that Chief Constables should be responsible for informing families once a misconduct hearing has been arranged to allow them to attend the hearing, as often families are unaware that the hearing is about to be held. It also recommends that the IPCC consider making formal written recommendations for the restriction of duties or suspension of police officers if it feels it is warranted.

1. Introduction

1. Introduction

*“Those who have the most power must be the most accountable” –
The Rev. Jesse Jackson³*

- 1.1 No police officer sets out on a shift with the anticipation that by its end he or she will be a witness to, or under investigation for the death of an individual in their custody or care. The possible suspension from duty, the months of delay and anxiety, possible family breakdown, the prospect of a misconduct hearing, prosecution and/or loss of livelihood, all pale in comparison to the enduring weight of the sense of responsibility for the avoidable death of another.
- 1.2 However grim these prospects may be, they also fade in significance when compared to the profound and sustained trauma and personal loss of a loved one in circumstances where the state has a moral and legal duty to ensure the safe custody of a son or daughter, father or mother or sister or brother.
- 1.3 This review seeks to address both sets of tragedy by aiming to prevent those circumstances giving rise to such deaths and by improving the ability for all other police officers elsewhere in the country to learn in a sustained way from any failure resulting in such tragedy. While the recommendations are aimed principally at reducing death and serious incidents in police custody, the successful outcome of their implementation is also to protect police officers from the risk of their own or a colleague’s avoidable failures.
- 1.4 More broadly, there is also the issue of institutional accountability and sustained learning where the failures are systemic. An absence of an effective mechanism for disseminating learning and ensuring implementation of the recommendations from Inquests and reviews means a fragmented and ineffective response, with little accountability until the next death. This review sets out to address the complacency that can persist in the absence of such a mechanism and makes recommendation for change.

Background

- 1.5 In January 2015 the then Home Secretary, the Rt. Hon Theresa May MP, met with the families of Sean Rigg and Olaseni Lewis and heard at first hand their experiences following the death of their loved ones.
- 1.6 Sean Rigg was a 40 year old Black musician who suffered from schizophrenia. Mr Rigg died on 21 August 2008 at Brixton police station, south London, following his arrest by Metropolitan Police Service (MPS) officers.

3 INQUEST family meeting

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- 1.7 Olaseni Lewis, known as Seni to his family, was a 23 year old Black graduate with plans for further postgraduate study. He died on the 4th of September 2010 after being restrained by up to 11 policemen while he was seeking help as a vulnerable voluntary patient at the Bethlehem Royal Hospital, Croydon.
- 1.8 In both cases it was not just the shocking immediacy and circumstances of the deaths that the families had to contend with, but also the appalling level of delays, obfuscations and institutional blunders that followed.
- 1.9 As a direct result of this meeting the then Home Secretary formally announced this independent review of deaths and serious incidents in police custody. On 23 July 2015 the Home Secretary said:
- “In my time as Home Secretary, I have been struck by the pain and suffering of families still looking for answers, who have encountered not compassion and redress from the authorities, but what they feel as evasiveness and obstruction. I have also heard at first hand the frustration of police officers and staff, whose mission it is to help people but whose training and procedures can end up causing bureaucracy and delay. And all this at a time when families are feeling vulnerable and confused and a police force is trying to come to terms with what has happened, whether it could have been avoided, and what needs to be done to prevent it happening again.”*
- 1.10 In the course of the announcement the Home Secretary also indicated that the families of those who have died in custody should be at the heart of the review and appointed Deborah Coles, Director of the charity INQUEST⁴, to act as an expert advisor to Dame Elish. Following her appointment, Dame Elish also established a Reference Group to the review. To further support the review, a study of the International Evidence on Deaths in Police Custody was commissioned to examine any international patterns that may be emerging or of assistance to the review. The Report of that study⁵ accompanies this Report.

Terms of Reference

- 1.11 The review has three principal aims:
- To examine the procedures and processes surrounding deaths and serious incidents in police custody, including the lead up to such incidents, the immediate aftermath, through to the conclusion of official investigations. It should consider the extent to which ethnicity is a factor in such incidents. The review should include a particular focus on family involvement and their support experience at all stages.
 - To examine and identify the reasons and obstacles as to why the current investigation system has fallen short of many families’ needs and expectations,

4 <http://www.inquest.org.uk>

5 Deaths in police custody: A review of the international evidence

with particular reference to the importance of accountability of those involved and sustained learning following such incidents.

- To identify areas for improvement and develop recommendations seeking to ensure appropriate, humane institutional treatment when such incidents, particularly deaths in or following detention in police custody, occur. Recommendations should consider the safety and welfare of all those in the police custody environment, including detainees and police officers and staff. The aim should be to enhance the safety of the police custody setting for all.

Families

- 1.12 There has been considerable anguish, anger and frustration over many years about the lack of accountability and learning following deaths in custody and the failure to hold the police to account where there is believed to be wrongdoing or criminality. There has never been a successful manslaughter prosecution of any officer either at an individual or senior management level for police-related deaths. This is despite verdicts of unlawful killing following Coroners' Inquests over the years and evidence of unlawful or excessive use of force or gross neglect. This situation has been very damaging to family and public confidence in the process and frustrates confidence in the prevention of abuses of power, ill treatment and misconduct.
- 1.13 Achieving effective and thorough investigations and inquests, as well as robust and meaningful change, involves enormous challenges, frustrations and obstacles, often at great personal cost to the emotional and physical health of family members, young and old. Too often families feel that their needs have been reduced to the lowest priority by institutions more concerned with defending their reputations than learning from their mistakes.

Previous reports

- 1.14 Much of the frustration felt by families can be attributed to the occurrence of the same failings time after time. This feature is evident from the many reviews, enquiries and reports looking at these very issues over the years. Despite clear, pragmatic recommendations and agreement for action from successive governments, the police and other agencies, some of the worst types of failings have persisted. As a consequence there may quite understandably be a degree of 'review fatigue'.
- 1.15 It cannot be said that these issues have not undergone considerable scrutiny in recent years. Recent Reports on matters concerning deaths in police custody include:
- Independent Commission into mental health and policing - Adebowale report, May 2013
 - http://www.turning-point.co.uk/media/621030/independent_commission_on_mental_health_and_policing_main_report.pdf

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- MIND report - mental health crisis care: physical restraint in crisis June 2013
 - https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf
 - HMIC/HMIP, Care Quality Commission and Healthcare Inspectorate Wales - A criminal use of police cells? A report examining the use of police custody as place of safety for those detained under section 136 Mental Health Act - 2013
 - <https://www.justiceinspectors.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf>
 - Review of the operation of Sections 135 and 136 of the Mental Health Act, December 2014
 - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf
 - Review of the IPCC's work in investigating deaths, IPCC, March 2014
 - https://www.ipcc.gov.uk/sites/default/files/Documents/deaths_review/Update_report_Deaths_review_March2015.pdf
 - Preventing Deaths in Detention of Adults with Mental Health Conditions, EHRC, February 2015
 - https://www.equalityhumanrights.com/sites/default/files/adult_deaths_in_detention_inquiry_report.pdf
 - The welfare of vulnerable people in police custody, HMIC, March 2015
 - <http://www.justiceinspectors.gov.uk/hmic/wp-content/uploads/the-welfare-of-vulnerable-people-in-police-custody.pdf>

Other Ongoing Reviews and Action

- 1.16 While this review was taking place there were a number of other ongoing developments about the vexed issue of deaths in custody or about circumstances which have an effect on the issues surrounding these deaths and serious incidents.
- 1.17 Following the verdict of the Jury in the Coroner's Inquest on the Hillsborough tragedy on 26 April 2016, the Home Secretary asked the Bishop of Liverpool to write a report to 'understand and learn from the families' experiences'.
- 1.18 Lord Alex Carlile is also chairing a review on the use of restraint which will report in due course.
- 1.19 Of particular significance to this review is the passage of the Policing and Crime Bill through Parliament at the time of writing. The Bill was introduced to Parliament on 10 February 2016 and has completed its Commons stages. It was introduced in the House of Lords on 14 June 2016, and completed its Committee stage on 9 November 2016. It will apply to England and Wales only.

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- 1.20 A number of measures in the Bill relate directly to the work of this review of Deaths and Serious Incidents in Police Custody, including an enhanced role for the Independent Police Complaints Commission (IPCC).
 - 1.21 If enacted, the Bill will increase the IPCC's powers, including allowing it to initiate its own investigations. The Government is also introducing a new system of IPCC-directed investigations, which reinforces the independence of the IPCC from the police in its approach to its investigations.
 - 1.22 Further measures in the Bill reform the governance arrangements of the IPCC, which will be renamed as the Office for Police Conduct (OPC). These reforms will replace the existing Commission structure with a new single head, the Director General, who will have responsibility for all investigative decisions.
 - 1.23 On mental ill health, the Policing and Crime Bill includes a number of provisions to help improve outcomes for people in mental health crisis, including removing the use of police cells as places of safety for those under 18 who have been detained under section 135 or 136 of the Mental Health Act 1983. It also reduces the use of police cells for adults and the current 72 hour maximum period of detention.
 - 1.24 This review makes recommendation for change which go beyond some of these important reforms.

The Legal Framework

- 1.25 The European Convention on Human Rights (ECHR) is an international treaty to protect human rights and fundamental freedoms in Europe. Drafted in 1950 by the Council of Europe, the Convention entered into force on 3 September 1953. The United Kingdom, as a Council of Europe member, was one of the original signatories to the Convention and was heavily involved in the drafting of the Convention.
- 1.26 The Human Rights Act 1998, formally enshrined recourse to Convention rights in British domestic law. These rights include those under Article 2, commonly known as the right to life, and Article 3, the prohibition on inhuman and degrading treatment. Deaths that occur during or following police contact may engage Article 2 and /or Article 3 as well as a possible breach of national criminal and/or civil law.
- 1.27 Article 2 of the European Convention on Human Rights also imposes a procedural obligation on the UK to conduct an investigation in certain circumstances including where the person has died while detained by the state; or has attempted suicide while so detained and sustained serious injury (or potentially serious injury); or where the State owed a duty to take reasonable steps to protect the person's life because the person was under the State's control or care; or where the person was killed by an agent of the State.

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- 1.28 An investigation conducted for the purposes of Article 2 should open up the circumstances, correct mistakes, identify good practice and learn lessons for the future so as to prevent recurrence of similar incidents.
- 1.29 To satisfy this procedural obligation, the State must initiate an investigation that is reasonably prompt, effective, carried out by a person who is independent of those implicated, provides a sufficient element of public scrutiny and involves the next-of-kin to an appropriate extent. This function is carried out in England and Wales by a number of agencies and office holders, including the IPCC and the Coroner.
- 1.30 The need for an independent investigation where there has been a sudden or unexplained death is also provided for in domestic law by the Coroners and Justice Act 2009; the Coroners (Investigations) Regulations 2013; and the Coroners (Inquests) Rules 2013. Inquests are usually held without a jury, but the 2009 Act states that a jury should be used if the deceased “died while in custody or otherwise in state detention” and the cause of death was violent, unnatural or unknown; the death resulted from the act or omission of a police officer; or the death was caused by a notifiable accident, poisoning or disease.
- 1.31 This report will consider the extent to which Article 2 and domestic law obligations are being met in England and Wales, what can be done to improve on how these obligations are addressed and whether there is a need for a national framework mechanism to ensure that, in future, sustained learning is implemented in a more consistent and robust way.

Trends in deaths in police custody and suicides following police custody

- 1.32 According to IPCC statistics there were 17 and 14 deaths in or following police custody in England and Wales in 2014/ 2015 and 2015/16 respectively (although these figures do not include deaths following police restraint where the police are called to help medical staff to restrain individuals who are not under arrest). These figures are in line with the average for the last seven years but lower than the levels seen in the late 1990s and early 2000’s. There were also 60 apparent suicides following police custody in 2015/16. Apparent suicides following police custody increased markedly between 2011/12 and 2012/13, from 30 to 64– although these figures are thought to be, in part, the result of improved identification of such deaths.
- 1.33 As with deaths in police custody, the majority of apparent suicides following police custody were male. More than half of those who died from apparent suicide following police custody between 2004/2005 and 2014/15 were aged between 31 and 50 and individuals arrested for sexual offences are much more likely to die from an apparent suicide following police custody compared to those arrested for other offence types.⁶

6 IPCC statistics

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- 1.34 Various factors are thought to have contributed to the historic reductions in deaths in or following police custody. The sharp reduction in deaths between 1998/99 and 1999/2000 from 49 to 31 was largely due to a reduction in suicides in police cells. This has been attributed to the removal of ligature points in cells that resulted in reduced deaths by hanging. Increased use of CCTV in cells, the introduction of the revised Police and Criminal Evidence Act 1984 (PACE), Code C⁷, to strengthen the risk assessment of detainees as well as the reduction in the overall number of arrestees going through police custody suites may also have all contributed to the reduction in deaths in custody during the period from 2003/4 to 2008/9 (36 to 15). The authors of the accompanying research report to this review indicate that there is however no definitive evidence to link these developments to the fall in the number of deaths.
- 1.35 Those who die in police custody in England and Wales are typically male, aged between 31 and 50, and from a white ethnic background. Other countries show a similar demographic profile. Natural causes have been the most common known cause of death in Police custody in England and Wales between 2004/05 and 2014/15, accounting for 51% of deaths in this period. Drugs and/or alcohol also featured as causes in around half of deaths (49%). An even higher proportion of those who died had an association with drugs or alcohol (82%).
- 1.36 Police use of restraint against detainees was identified as a cause of death by post-mortem reports in 10% of deaths in police custody between 2004/05 and 2014/15. However, a higher proportion of deaths would have restraint used at some point during detention. Use of restraint was found to be more prevalent in cases of Black, Asian and minority ethnic (BAME) individuals who have died in police custody than in deaths of white people. Similarly, police use of force has also been found to be greater amongst those with mental health problems. In 2014/15 people who identified themselves as Black or Black British were three times more likely to be arrested for notifiable offences than those who identified as white.
- 1.37 While the police have achieved a significant reduction in the numbers of those committing suicide in custody, those dying in the course of or following restraint continue to show very similar features to many other deaths of a similar nature over the years. Too many individuals are still dying following a failure to recognise and deal with their medical frailty while in custody. The stigma and shame attached to an allegation of offending along with fear of the consequences also requires the police to anticipate the prospect of suicide in vulnerable arrestees and to take steps to reduce the likelihood of that outcome prior to the release of the arrestee on bail.

7 <https://www.gov.uk/government/publications/pace-code-c-2014>

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- 1.38 This review seeks to examine the persistent circumstances of deaths in and following custody, how well the state responds to its legal obligations to investigate these and to involve the family of the deceased in a meaningful way. How well equipped are those tasked with keeping us all safe from harm to learn from and prevent such tragedies in the future?
- 1.39 By pulling together for examination the most significant variables that create the circumstances in which such deaths continue and providing fundamental but pragmatic proposals for change, it is hoped that that the state can diminish further the likelihood of deaths in police custody. Where such deaths do occur, the ability of the family of the deceased to participate meaningfully in the investigations that follow must be at the heart of an adequately resourced, expert and speedy process.

Summary

- 1.40 Every death in police custody is a tragedy, but it would be misleading to conclude that every such death can be avoided. Sometimes, despite the best efforts of everybody involved, people will die no matter where they happen to be at the time of death.
- 1.41 However, where there are similar failings that are repeated over many years, and the same patterns reveal themselves time after time, it is evident that much more can be done to prevent these deaths from occurring.
- 1.42 People who spend time in police custody are not generally a group who campaign collectively. Many are vulnerable or marginalised within society, for example, they may have mental health problems or be repeat offenders, and many feel shame and a stigma about having been in police custody. While there are community groups who campaign on particular policing issues, such as stop and search, the police custody experience is not generally the subject of widespread or sustained public debate.
- 1.43 When these tragic deaths occur they trigger an investigation which should shine a light upon the detainee experience, prevent recurrence and, where appropriate, hold the state and its agents to account. The manifest failure to meet these objectives in so many cases over several years has propelled family members of those who have died in police custody into the public arena to campaign at great personal emotional cost. Inquests and other deaths in custody investigations should provide the opportunity for a close and critical examination of police custody and for families to contribute directly to the process. This objective is not yet being achieved adequately or consistently and substantial change is required to allow these legal and moral obligations of the state to be fulfilled.

2. Restraint

2. Restraint

Introduction

- 2.1 The need to intervene to restrain the conduct of individuals in our communities occurs in a wide range of circumstances. It is a daily occurrence and a duty for those in whom society places its trust to police our communities. Such duties involve the power to detain or arrest where criminal conduct is suspected or where the welfare or life of that individual or others is at serious risk, as well as in other emergency settings.
- 2.2 The powers that flow from those duties are immense in their potential impact on citizens and are regulated by a complex framework of laws and regulations to prevent abuse or negligence in the exercise of those powers. The process of detention or arrest by the police is the point at which the citizen is most closely exposed and made vulnerable to the power of the State. When the citizen dies during or following such an encounter the State and its officers must be held to account.
- 2.3 How those powers are exercised is also governed by the competence and integrity of the individual police officer as well as the wider Police Force within which he or she operates. In addition to law, training and guidance on how officers should approach encounters that may lead to detention, the community relies on the professionalism, wisdom and courage of police officers to approach incidents which may result in harm to the officers or others. These are often situations from which most in the community would wish to remove themselves immediately for their own personal safety.
- 2.4 We therefore ask a lot of our police officers in the 21st Century and expect that they will be equipped with the skills to reduce, so far as possible, the threat of harm and danger to themselves and others arising from the perceived potential for violence. These various circumstances may require high levels of physical competence but, most importantly, emotional intelligence and empathy to diminish the need for physical restraint with all of its attendant risks. The recent announcement by the College of Policing⁸ that all new police officers in England and Wales will have to be educated to degree level from 2020 is welcome as it reflects the reality of the complexities of modern policing and the increased intellectual challenges and demands made of officers.
- 2.5 Given the inherent risks to both officers and those detained in the event of the use of physical force, the ability to de-escalate circumstances which may lead to a violent encounter are paramount in the skills set of the individual officer. Compliance with an officer's instruction can be achieved through a hierarchy of approaches. Persuasion, calming techniques and negotiation, known collectively as de-escalation, may have

8 <http://www.bbc.co.uk/news/uk-38319283>

a more effective impact in securing such compliance than directory commands that escalate tension and the probability of resistance.

- 2.6 Circumstances of danger or urgency may not however always permit de-escalation to take place and the law permits the use of physical restraint, use of police batons, sprays and Taser® equipment and, in the most extreme circumstances, firearms, where such use is necessary and justified. The use of any physical force should be contemplated only where absolutely necessary, rather than as a default position to achieve compliance.
- 2.7 Deaths following the use of restraint and force by the police in England and Wales are among the most serious of all deaths in custody here. The death of Roger Sylvester in 1999 led to what was hoped would be wide scale changes around the use of restraint. A number of methods of physical restraint have been deployed by police officers over the years and the dangers associated with certain approaches have been identified in a significant number of inquests in England and Wales as well as in litigation elsewhere.

“Deaths following the use of restraint and force by the police in England and Wales are among the most serious of all deaths in custody.”

- 2.8 The particular dangers around the use of prone restraint became largely established and more notorious through police guidance and training. Prone restraint, a particularly perilous method of physical restraint, is defined by the Care Quality Commission as:
- “... holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.”⁹*
- 2.9 More than fifteen years since the death of Roger Sylvester deaths continue to occur in circumstances involving the use of restraint, particularly in those suffering a mental health crisis.
- 2.10 IPCC statistics indicate that of 17 deaths in or following police custody in 2014/2015, 10 followed the use of restraint, and in 2015/16 of 14 deaths in or following police custody, six followed the use of restraint¹⁰. In addition there are further deaths following police restraint not included in the IPCC statistics because they occur where the police are

9 https://www.cqc.org.uk/sites/default/files/20160422_briefguide-Restraint_physical_mechanical.pdf

10 Deaths during or following police contact, Statistics for England and Wales, IPCC, 2015/16

called to help medical staff to restrain individuals who are not under arrest (there were two such deaths in 2015/16). There have been many highly publicised deaths over the years where restraint has been a significant factor in the cause of death, including those of Sean Rigg, Kingsley Burrell, Olaseni Lewis and Thomas Orchard.

- 2.11 Such deaths have led to critical findings at Inquests, and occasionally reviews, but the emergence of the same themes in many of these deaths is indicative of a failure to learn lessons. There is also evidence to suggest that dangerous restraint techniques and excessive force are disproportionately used on Black, Asian and minority ethnic (BAME) people (see Chapter 5, Ethnicity).

Mental Health and restraint

- 2.12 Of particular concern is the evidence that many of those who die following the use of physical restraint suffer from mental ill health. There are usually two sets of circumstances in which police restraint of mentally unwell people is exercised. The first will follow an emergency call from a member of the public, usually because someone is seen acting erratically or displaying disturbed behaviour in public, or when ambulance personnel request police assistance at the point of restraint in a public setting.
- 2.13 The second will be where police assistance is requested from healthcare staff in mental health settings. This should be as a last resort, but even though staff at such facilities will usually be better trained and more experienced in dealing with disturbed behaviour from a patient, the police may be called out to help restrain a vulnerable person within the hospital. There are also other circumstances, such as the police encountering someone on the street by chance, following a stop and search.
- 2.14 In 2016 the Mental Health and Restraint Reference Group¹¹ developed a Memorandum of Understanding (MoU) between national police and health partners to offer guidance on how the police should act in NHS mental health settings where the staff consider restraint is necessary and that they themselves are unable to administer it without police assistance. This procedure is described as a last resort. De-escalation techniques¹² should be deployed wherever possible.
- 2.15 This Group has highlighted the need for local solutions. In written evidence to this review, NHS Providers, the membership organisation and trade association for the NHS acute, ambulance, community and mental health services whose members treat patients and service users in the NHS, stated that:

“The work of this group has established that locally tailored arrangements between police forces and health partners are essential to building a shared understanding of the circumstances and protocol for engaging police to deploy restraint and what

11 An expert reference group of police officers, mental health and restraint experts as well as service users and other representative groups, coordinated by the College of Policing

12 Usually verbal techniques to defuse situations of potential violence and resolve them without the professionals resorting to the use of coercion or physical force

post-incident review processes should take place in order to learn from and prevent where possible further incidents.”

- 2.16 During this review healthcare professionals expressed their concerns that their colleagues may not be challenging the approach of individual police officers to the restraint used in such circumstances. Instead NHS personnel were deferring to the police at the scene of the incident. This may be because the presence of a police officer appears to make the incident an issue of law and order, and healthcare professionals may feel that they cannot intervene. According to one police officer who spoke to this review, police officers in such scenarios would often welcome medical workers taking charge of such a scenario.
- 2.17 Where the police have been called to a mental health setting a designated police officer in charge should, either in transit to the hospital or on arrival, be given urgent briefing on the needs of the patient and the incident by the designated nurse in charge. The best approach should, where possible and time permits, be agreed between them. Ideally, healthcare professionals should take the lead in such decision making to ensure the physical welfare of the patient is not lost sight of in the determination to subdue the behaviour of the patient.
- 2.18 In their written evidence to this review, members of a law firm with considerable experience of deaths in state custody explained the police are increasingly being called to assist medical staff in the management of difficult patients. Where there is police interaction with mentally ill people, the police need to be mindful of the unique vulnerabilities of the patient. As Bhatt Murphy state:
- “The subject may not even recognise the individuals dealing with them as police officers and they are unlikely to be in a position to acknowledge the officers’ authority: tactics which might work on a busy high street after the pubs have emptied may not be appropriate with someone who is mentally unwell...The usual commands to ‘stop resisting’ may well be meaningless to such a person, and an aim of securing compliance as opposed to control is unlikely to succeed.”*
- 2.19 In addition, the 2013 MIND report Mental health crisis care: physical restraint in crisis¹³ describes the particular distress caused to mentally vulnerable people by face down restraint:
- “Face down physical restraint is a life threatening form of physical restraint because of the severe impact it can have on breathing. It is a disproportionate and dangerous response to someone’s behaviour when they are in a mental health crisis. Face down physical restraint has no place in healthcare settings and there must be an immediate end to its use.”*

13 https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

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- 2.20 It may be a natural response to default to face down restraint, especially if a person is struggling and spitting, but it should be recognised that this carries grave inherent risks. College of Policing guidance on restraint¹⁴ states that there is an increased risk of causing positional asphyxia when restraining those of particularly small or large build or those who have taken drugs, medications (anti-psychotics) or alcohol. It also states that officers should keep the period for which it is used to a minimum. The MIND report itself acknowledges that some NHS Trusts have abandoned its use altogether and are able to rely on less forceful restraint techniques for vulnerable people. Less forceful but effective restraint techniques for vulnerable people need to be considered. These could include the use of effective de-escalation skills, the avoidance of prone restraint, and constant monitoring of vital signs.

Positional asphyxia

- 2.21 Positional asphyxia is a form of asphyxia that causes death when a person's position prevents them from breathing properly. It may occur following the use of certain restraint techniques, for example, in face down or prone restraint mentioned above.
- 2.22 A 2011 review¹⁵ of medical theories and research relating to restraint related deaths commissioned by the Independent Advisory Panel (IAP) on Deaths in Custody¹⁶ set out its findings on what specifically constitutes positional asphyxia:

“Ventilation in a healthy human involves two key factors: movement of the ribs by the intercostal muscles and movement of the diaphragm (Parkes, 2000; Reay, 1992). The chest expands and the diaphragm contracts, drawing air into the lungs (inhaling). The ribs and diaphragm then relax, releasing air from the lungs (exhaling). When an individual is restrained or contained in a prone position, three things happen that compromise the body's ability to breathe:

“1. There is possible occlusion of the respiratory orifices (Belviso, 2003)

“2. There is a compression by weights or restriction to movement of the ribs limiting their ability to expand the chest cavity and breathe (Parkes, 2000; Stratton, et al., 2001);

“3. The abdominal organs may be pushed up, restricting movement of the diaphragm and further limiting the available space for the lungs to expand (Parkes, 2000; Reay, 1992).

14 <https://www.app.college.police.uk/app-content/detention-and-custody-2/control-restraint-and-searches/>

15 <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Caring-Solutions-UK-Ltd-Review-of-Medical-Theories-of-Restraint-Deaths.pdf>

16 See Chapter 17, Sustained Learning

“Consequently, even without any other contributing factors, simply restraining an individual in a prone position may be seen as restricting the ability to breathe, so lessening the supply of oxygen to meet the body’s demands. Restriction of the neck, chest wall or diaphragm can also occur when the head is forced downwards towards the knees.”

- 2.23 Following the death of Roger Sylvester in 1999 the Metropolitan Police Service (MPS) issued a Police Notice defining positional asphyxia¹⁷. The College of Policing Detention and Custody Authorised Professional Practice (APP) section on training in control and restraint also covers this issue. However, there are a number of Coroner findings that suggest that some officers still fail to recognise and act upon the risks of positional asphyxia.
- 2.24 In the inquest into the death of Frank Ogboru in 2010 the jury’s narrative verdict stated that:
- “All officers involved in restraining Mr Ogboru were trained to recognise the risk factors of positional asphyxia. A combination of these risk factors was clearly present throughout the process of controlling and restraining Mr Ogboru. The officers did not recognise these risk factors in accordance with their training, because the officers were entirely focussed on controlling and restraining Mr Ogboru.”*
- 2.25 In 2010 the Independent Advisory Panel (IAP) prepared a report on themes arising from a review of Coroners’ Rule 43 reports (now called Prevention of Future Deaths reports), from narrative verdicts and investigation reports where restraint was identified as a direct cause or contributory factor in the death¹⁸. The cases examined covered the period from 1998/99 to 2008/09. Of the 29 cases examined, positional asphyxia was a primary or secondary cause of death in six. Since then there does not appear to have been any examination of the extent to which positional asphyxia remains a feature of restraint deaths nationally.
- 2.26 The 2011 review of medical theories and research relating to restraint related deaths over the previous decade, commissioned by the IAP, and conducted by Caring Solutions (UK), stated that:
- “Positional asphyxia appears to be implicated for at least 26 of the 38 deaths (whether or not given as a verdict) because of struggle/physical stressors prior to restraint, number of staff involved and, in particular, because of the length of time of the restraint and position of the individual.”*

17 MPS Police Notice 12/99

18 <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/12/Review-of-Rule-43-and-Narrative-Reports-on-Restraint-Deaths.pdf>

Training

- 2.27 As mentioned above, there is a need for mandatory training and development of police officers in the use of restraint. As things stand, individual forces are able to choose exactly how and to what extent they deliver officer safety training.
- 2.28 The Police Federation, in evidence to this review, agreed that the training and development of police officers and staff in the safe handling and detention of persons, including restraint, should now be mandatory and delivered to a 'suitably accredited and consistent standard'. Effective training is crucial but a transformation in culture away from physical intervention as the default position to one of de-escalation will require strong leadership and recognition of the wider skills set required of our police officers in the 21st century.
- 2.29 The Police Federation stated that:
- “Training, and regular refresher training, in a range of skills aimed at improving the safety of detained persons from the point of arrest to the point of release should be provided to all police officers and police staff in contact roles. This should include particular focus on de-escalation techniques and tactical communications in addition to the safe and proportionate use of physical restraint and the use of force.”*

Length of prone restraint

- 2.30 All forms of restraint are potentially dangerous, but a key feature that continually arises in restraint-related death is the length of time the deceased was kept in prone restraint, where the body is flat and face down. The amount of weight and the length of time during which the officer or officers put pressure on the back, neck, or shoulders of the subject while in the prone position needs to be considered.
- 2.31 It has long been identified that prone restraint carries inherent dangers. The MPS Review of 2004 following the death of Roger Sylvester and the issues arising from the Inquest, recommended that:
- “Officer safety training should stress that restraining a person in the prone position is potentially dangerous and include appropriate techniques to re-position violent persons from the prone position as quickly as possible.”*
- 2.32 Re-positioning should take place immediately. Prone restraint is highly dangerous, especially when weight is applied to the rear of the body, and there is no recognised 'safe' period of time during which it can be used, given that all detainees will have different needs and vulnerabilities. The MPS Review of 2004 considered whether to recommend a time limit but concluded that it was neither safe nor practicable to set one and that the prone position should be for “the minimum time necessary to achieve control”.

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- 2.33 The use of prolonged restraint by police officers, including its use with the additional deployment of restraint equipment, continues. Some deaths have followed the use of prone restraint lasting an hour or longer (for example the deaths of Kingsley Burrell and Rafal Delezuch). Other incidents have been followed by death within only a short time of the restraint.
- 2.34 Guidance to police officers does not give any set minimum or maximum time during which prone restraint can be used. Any attempt to do so could make it more likely that police officers would take the opportunity to use all the ‘allotted’ time, whether it was required or not. Instead, there should be an understanding that prolonged restraint is very unsafe per se, and should be avoided. If used at all, this should be for the absolute minimum time necessary. All officers must be made aware of and understand the grave danger presented by any prone restraint.
- 2.35 The introduction of spit hoods, combined with this form of restraint can only exacerbate the sense of panic in those suffering from an acute mental health crisis and inhibit the possibility of de-escalation. The ability to monitor vital signs is also prevented and may present a further danger in these volatile circumstances.

Excited Delirium/Acute Behavioural Disturbance

- 2.36 Following the May 2015 Inquest into the death of Kingsley Burrell, the Coroner noted in her report that:
- “Medical evidence at the Inquest confirmed that Mr Burrell was suffering from acute behavioural disturbance. As a result he continued to struggle against restraint. Patients with this condition are at risk of death through prolonged restraint and struggle against restraint. Most training in relation to restraint deaths focuses on positional asphyxia. Position in this case was not a major consideration. It was clear from the Inquest that there was a lack of understanding of how to treat someone with acute behavioural disturbance.”*
- 2.37 Acute Behavioural Disturbance is often cited in deaths in custody cases under the heading of “Excited Delirium” – a contentious and controversial term used to describe a constellation of symptoms that may be indicative of an acute medical crisis. Excited Delirium is said to be a form of Acute Behavioural Disturbance. It has been described as an agitated, aggressive, paranoid behavioural disturbance where the individual appears to have near superhuman strength and is seemingly impervious to pain. In 2010 the Faculty of Forensic and Legal Medicine (FFLM) stated:
- “Of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life threatening.”*
- 2.38 The very existence of Excited Delirium is however strongly disputed amongst medical professionals. As stated in the 2011 Independent Advisory Panel (IAP) study:

“The exact incidence of excited delirium (ED) is impossible to determine as there is no current standardised case definition to identify this state (deBard et al, 2009). It is currently not a recognised medical or psychiatric diagnosis according to either the Diagnostic and Statistical Manual of Mental Disorders (DSM-IVTR) of the American Psychiatric Association or the International Classification of Diseases (ICD-9) of the World Health Organization (Samuel, 2009).”

2.39 Given this lack of consensus, the use of the term is very controversial. Some believe it is used as an attempt to explain away a death and deflect attention from the use of force. These concerns arise because Excited Delirium is often put forward as a cause of death although it refers to a psychiatric condition (albeit one that can be induced by physiological factors such as the use of cocaine and other narcotics), and it is not fatal absent other causes – such as restraint, or drug toxicity.

2.40 In addition, any reference to Excited Delirium might itself become the focus of an investigation, and the use of any restraint may be subsequently downplayed. Excited Delirium is often used interchangeably with Acute Behavioural Disturbance.

2.41 An examination of the term Excited Delirium from a psychiatric perspective was conducted by forensic psychiatrist Dr Maurice Lipsedge, who conducted a literature review published in June 2015¹⁹. In this review he stated:

“The term Excited Delirium (ED) is being used to explain sudden and unexpected restraint-related deaths. Since the 1990s ED has often been identified as the principal cause of death in restrained individuals, rather than the restraint procedure itself.”

2.42 He further stated:

“Forensic pathologists and psychiatrists attach different meanings to the term delirium. For psychiatrists delirium is a specific technical term which implies a grave and potentially life-threatening underlying physical illness. If a patient dies during a bout of delirium psychiatrists assume that there will be autopsy evidence to demonstrate the primary underlying organic cause.

“Conversely pathologists appear to be using the term excited delirium to refer to restraint-related deaths in either highly disturbed cocaine users or psychiatric patients in a state of extreme agitation. In these cases there is no underlying physical disorder other than a terminal cardiac arrhythmia.”

2.43 He stated his opinion that Excited Delirium is not generally, of itself, a cause of death:

“The primary psychiatric causes of severely disturbed behaviour include mania, acute schizophrenia and brief psychotic disorders. Excluding suicide, these disorders do not generally in and of themselves carry the risk of a fatal outcome from physiological causes, although obviously these individuals might be involved in fatal accidents.”

19 <http://www.ncbi.nlm.nih.gov/pubmed/26055153>

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- 2.44 Dr Lipsedge went on to explore why the term Excited Delirium is in itself controversial, when compared to the condition of ‘delirium’.

“While delirium is a clearly defined syndrome with well established and specific clinical features and demonstrable underlying organic causes, the adjective “excited” in ED is used to describe uncontrollable, violent and destructive behaviour which requires restraint and which is generally presumed to be caused by intoxication with recreational drugs, or by a severe psychiatric disorder.”

- 2.45 Whatever the true medical condition there is clearly a constellation of signs and symptoms that signify that a person having an acute medical crisis requires immediate medical attention, and should not be restrained (except in the most extreme, life threatening circumstances).

Struggle and restraint

- 2.46 With the exception of positional asphyxia (the risks of which are now embedded in police training) there is limited police recognition of the dangers of restraint involving a struggle with a person who is in a heightened physical and mental state. In such circumstances the individual’s system can become rapidly overloaded, leading to death.

“There is limited police recognition of the dangers of restraint involving a struggle with a person who is in a heightened physical and mental state.”

- 2.47 It is this perception of the dangerous and violent detainee who requires restraint that can be a factor in restraint related deaths. As Dr Lipsedge notes in his literature review:

“As a result of paranoid delusions they might believe that they are in mortal danger. Their extreme fear might cause a cardiotoxic release of catecholamines. Other physiologically dangerous effects of the struggle against restraints include metabolic acidosis²⁰. The patient’s extreme exertion may persist, partly because of fear, partly because of reduced pain perception.”

- 2.48 An understanding of these mechanisms and of the physiological consequences that flow where physical restraint is used on those who present a high risk has developed only slowly.

20 A condition in which there is too much acid in the body fluids

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- 2.49 For example, INQUEST state that some pathologists instructed in restraint-related deaths on behalf of families of the deceased have identified increases in lactic acid in the body and hormones such as adrenalin in the blood which may suggest evidence of prolonged restraint or struggle against restraint.
- 2.50 Deaths involving mental health and restraint may follow from the use of restraint techniques designed for use on all detainees, and not tailored for people who may be mentally unwell. Such restraint can cause fear in a person who is delusional and who may feel that they are fighting for their life, thus leading to a prolonged struggle. Someone suffering an acute mental health crisis may simply not recognise the police, or be able to process simple instructions.
- 2.51 The College of Policing Authorised Professional Practice (APP) on Detention and Custody (Control, restraint and searches) first published in July 2013 and reviewed in May 2016, states:
- “Prolonged restraint and struggling can result in exhaustion, reduced breathing leading to build up of toxic metabolites. This, with underlying medical conditions such as cardiac conditions, drugs use or use of certain antipsychotics, can result in sudden death with little warning. The best management is de-escalation, avoiding prone restraint, restraining for the minimum amount of time, lying the detainee on their side and constant monitoring of vital signs.*
- “... Officers should note that the effects of a violent struggle or restraint and build-up of lactic acid can exacerbate the effects of drugs, alcohol or medication.”²¹*
- 2.52 College of Policing training also explicitly references Excited Delirium. It is described as the most extreme form of Acute Behavioural Disturbance. The training is clear that people with this condition should be restrained only in an emergency, and should be taken to hospital immediately by ambulance. Psychotic behaviour which is a critical medical emergency does exist as a perilous state and police should appreciate the dangers of imposing pressure or strain on the body as restraint can cause physiological changes which can lead to death.
- 2.53 In its March 2015 report, ‘The Welfare of Vulnerable People in Police Custody,’ the HMIC found that:
- “All forces provided some training for staff on restraint and de-escalation techniques. However, staff seemed unaware...that resistance might be caused by fear or mental disturbance (and so the person would be more amenable to reassurance than restraint).”*

21 <https://www.app.college.police.uk/app-content/detention-and-custody-2/control-restraint-and-searches/>

The safety officer approach

- 2.54 The Metropolitan Police Service Review of 2004 addressed the need for a ‘supervisor’ to monitor the health and wellbeing and vital signs of the restrained person (as currently happens in the prison setting). It recommended that such a safety officer should take charge of the incident and actively control the restraints being applied by the other officers.
- 2.55 The Independent Advisory Panel on Deaths in Custody produced Common Principles of Safer Restraint²² in July 2013 which provide for this model. The Principles state:
- “If three or more staff are actively involved in a restraint then one of those staff must be in control of the restraint (Controller) and it must be clear at all times, to all those involved in the restraint who the Controller is.”*
- 2.56 Furthermore, in written evidence to this review, INQUEST stated that:
- “Following the Kingsley Burrell inquest at the instigation of the coroner, an NHS Patient Safety Alert was issued on the importance of monitoring vital signs during and following restraint, to be circulated to all NHS staff who may be called upon to support restraint of patients. No similar alerts appear to have been targeted at police officers conducting such restraints, nor is it known whether this forms a part of restraint training by forces.”*
- 2.57 There may be scenarios where too few officers are present to be able to effectively implement a safety officer approach, but in such cases the need to constantly monitor vital signs must be completely understood by those officers present.

Alternatives to manual force

- 2.58 The use of restraint equipment has been seen in the past as a possible solution to the use of manual force by police officers. One such device is the Conductive Energy Device (CED). This is more commonly referred to as Taser®, which is a brand name. In written evidence to this review, the Police Federation stated that the use of CEDs could reduce instances of police restraint:
- “As well as providing greater public reassurance, we consider that it will also improve the safety of police officers and detained persons and lead to a reduction in the instances of physical restraint.”*
- 2.59 This view was also cited in oral evidence given to this review by Dr Meng Aw-Yong, (Medical Director with the Metropolitan Police Service and former Forensic Medical Examiner), who stated that the use of CEDs can give a short window to allow for sedation to be administered by medically trained personnel. In his view this would carry less risk to the detainee than being physically restrained by multiple officers.

22 <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/07/IAP-common-principles-for-safer-restraint.pdf>

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- 2.60 The use of CEDs is highly controversial, as the death of Dalian Atkinson in August 2016 highlighted. According to the Home Office, CEDs were fired in 19% of police deployments in 2015 (equating to 1846 discharges). In the majority of cases, the drawing of the device or pointing the sighting-laser (known as red-dotting) was sufficient to defuse a situation.
- 2.61 However, since CEDs were authorised for use by the police in the UK, there have been some incidents where the death of an individual occurs during or soon after the operation. The use of a CED has been found to be one of the contributory factors in two deaths. In the case of Jordon Begley, the inquest jury found that the use of the device was one of a package of stressors - drug use, alcoholism, recent medical complications, the police use of restraint and other emotional factors - that ultimately caused the cardiac arrest. There was also the death of Anthony Pimlott from first degree burns: he had doused himself in petrol and was holding a lighter when the CED was fired.
- 2.62 The potential danger of CED use has been highlighted by several studies. A literature review ‘Police use of Tasers in mental health emergencies: A review’²³ was published in the International Journal of Law and Psychiatry in July 2014 and highlights some of the concerns that have been raised:

“The overall conclusion of this research is that Tasers (sic) are generally safe with healthy, sober subjects, and when used in accordance with the manufacturer’s and police departments’ guidelines, but there are several important provisos to this conclusion...Tasers (sic) also have the potential to cause severe injuries and other adverse effects, resulting from the unique penetrating action of Taser (sic) prongs, from muscular contractions, or from falls.”

- 2.63 The physical frailty and vulnerability of many of those who are detained or arrested by the police in England and Wales is discussed at Chapter 8 but the level of risk to individuals from the use of CEDs must be assessed more widely, taking into account that those who are subject to arrest and detention by the police are much more likely to have physical vulnerabilities than the general population. It is wholly unacceptable if CEDs are only safe for use against those who are in good physical health.

- 2.64 The report further states:

“...a number of newspaper and police reports have recorded sudden unexpected deaths following use of Tasers (sic). In many cases these deaths have occurred following use of multiple means of restraints, and in individuals affected by stimulant drugs.

“Overall, the literature on health effects of Tasers (sic) on people with mental illness suggests that the risks are small but not negligible. Authors are consistent in concluding that Tasers (sic) are not free from risk, a conclusion also reflected in Taser (sic) product information.”

23 https://www.researchgate.net/profile/Anthony_OBrien/publication/260995692_Police_use_of_TASER_devices_in_mental_health_emergencies_A_review/links/53fba4c60cf2364ccco3fed4.pdf

2.65 Concerns with CEDs are not confined to the UK. In the USA, Taser International (a developer, manufacturer, and distributor of CEDs) and police forces have faced litigation proceedings following controversial usages of its devices²⁴. In Canada, the high profile death of Robert Dziekanski in 2007 was found by the Coroner in 2013 to have been a “homicide...in the presence of a physical altercation and multiple deployments of a conducted energy weapon”.²⁵ Police Forces are actively contemplating a further role out of the use of Taser® equipment. Independent international research should be conducted as soon as possible to study the safety and efficacy of CED usage in both the United Kingdom and other countries.

2.66 The use of other restraint equipment has also been linked to deaths in England and Wales. As INQUEST stated in written evidence to this review:

“...many of those who die following restraint have had handcuffs and leg restraints applied, frequently whilst they are in a prone position, this includes Kingsley Burrell, James Herbert, Thomas Orchard, Darren Neville, Rafal Delezuch and Jacob Michael.”

2.67 This concern is also supported by the following case studies:

“Thomas Orchard: *Thomas had a history of mental illness and in September 2012 was showing signs of a relapse following interruptions to his medication. On 3rd October 2012 police officers attended Exeter City Centre in response to reports of his increasingly bizarre and disorientated behaviour. He was dealt with by seven police officers, handcuffed to the rear and restraints applied to his legs and ankles. He was arrested for a public order offence, carried into a police van, and taken to Heavitree Road Police Station. Upon arrival an Emergency Response Belt was placed over his face. He was physically restrained, mostly in the prone position, immediately prior to his death.”*

“James Herbert: *in June 2010 the police were called to attend due to reports of James behaving bizarrely in the street in Wells. Following detention under section 136 three sets of limb restraints were applied around James’s wrists, ankles and knees and he was placed into a cramped caged area in the back of a police van, wearing a winter coat on a hot day. He was transported 30 miles to Yeovil Police Station, a journey of over 40 minutes. At some stages the vehicle was travelling at 50/60 miles per hour and James was unsecured, in limb restraints in the van. He was removed unresponsive from the van.”*

2.68 As a consequence of such deaths many believe that restraint equipment not only fails to reduce risks to life but that its use has become commonplace, resulting in inappropriate and sometimes degrading use in large numbers of non-fatal cases. In its March 2015 report, ‘The Welfare of Vulnerable People in Police Custody’, concerning the inspection of police stations, Her Majesty’s Inspectorate of Constabulary (HMIC) states that:

24 For example: <https://casetext.com/case/williams-v-taser-international>

25 <http://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/reports/investigative/robert-dziekanski.pdf>

“Inspectors were concerned by the extent to which restraint equipment was used to prevent people who were mentally unwell from harming themselves. The range of equipment available to use varied between forces, but (in total) included handcuffs, leg restraints, spit hoods, emergency restraint belts, body cuffs and Taser (sic). We were particularly concerned about the use of emergency restraint belts in one police force. Data supplied by the force suggested that staff were using the belt regularly, yet there was a lack of clarity among staff as to when the belt should be used and how. Of three CCTV recordings we reviewed of use of this belt, we asked that two were referred immediately for internal professional standards investigation.”

- 2.69 The use of restraint equipment is not of itself a safe alternative to the use of manual force, and has been linked to deaths. It should be acknowledged however that officers can find themselves in difficult situations where somebody suffering from mental ill health may pose a serious and imminent risk to themselves or others. In the absence of support from other agencies, and a failure of de-escalation techniques, the police may have to intervene with some form of restraint, but its use should be strictly limited and subject to robust monitoring and training.

Transportation in police vehicles

- 2.70 Concerns have been expressed in the past about cases where unsupervised transportation in police vehicles has preceded a collapse or even death of a detainee, as the following case studies illustrate:

“Sean Rigg: *Sean was restrained in South London by police officers in August 2008 after calls for police assistance from staff at a hostel where he lived which provided housing for people receiving mental health support in the community. He was held in the prone position for 8 minutes and placed in a V shape in the footwell of the caged area of a police van. His physical health declined during the journey. When he was brought into the police station he was not fully conscious and lost consciousness within 8 minutes of leaving the van.”*

“Leonard McCourt: *Police officers attended Leonard’s home in response to a 999 call. After they left Leonard approached a police car and was pepper sprayed and forcibly placed on the floor in the rear of a police van and transported to a police station. No supervision or monitoring of his condition took place during the journey to the police station indeed there was no interaction with him at all. He was found to be unresponsive on arrival.”²⁶*

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- 2.71 There is no reason why an ambulance cannot be used to transport an already restrained individual if there is a need for medical care or a mental health assessment under section 136 (see Chapter 4, Mental Health). The Care Crisis Concordat of 2014 states that where such patients are being actively restrained they need to be transferred to hospital as an immediate priority.
- 2.72 Police guidance also states that an acute mental health crisis is a medical emergency that requires transportation to A&E. The draft APP on mental health also indicates that if a detainee is being restrained the ambulance service response should be escalated to an eight minute response time.
- 2.73 Even if there is no use of section 136, any detainee restrained and transported in the cage of a police van in restraint equipment (generally handcuffs and leg restraints) should be monitored throughout the journey. Such monitoring would be assisted with the use of cameras (as well as providing a record of police and detainee actions during the journey) and steps should be taken to introduce these to all police transportation. This does not however reduce the need for physical, human checks nor be seen as a substitute for such human checks.

Recording of police use of force

- 2.74 There is a need for national mandatory recording of the use of force by the police service, similar to that adopted by the Prison Service. In 2004 the MPS Review noted that the MPS did not maintain a database of the frequency and circumstances in which force is used and therefore could not demonstrate whether its use of force was appropriate, proportionate and necessary. In the March 2015 HMIC report, ‘The Welfare of Vulnerable People in Police Custody’ it was explained that:
- “Forces did not know with any certainty what type of restraint had been used, how often and in what circumstances. There was little evidence of management review or analysis of the use of force in custody in any of the forces we visited. Where information was available, this was primarily used to inform officer safety training rather than to improve practice.”*
- 2.75 Since then, the former Home Secretary instituted national data collection, which began in April 2016. Such data collection needs to record a range of variables, in particular ethnicity and mental health, in a consistent, systematic way across police forces. Only in this way can police forces have more confidence that their use of force and restraint is proportionate and necessary. It can also formally ascertain if force is used disproportionately on BAME people, and those suffering from mental illness. There also needs to be robust data collection on near misses and non-fatal serious incidents by the police and IPCC.

Recommendations:

- Police practice must recognise that all restraint can cause death. Recognition must be given to the wider dangers posed by restraining someone in a heightened physical and mental state, where the system can become rapidly and fatally overloaded. Position is not always the determining feature. As great a danger can arise from the struggle against restraint as the restraint itself.
- Police must be held to account both at an individual and corporate level, where restraint has been found to have been used in an unnecessary, disproportionate or excessive way.
- Healthcare professionals should take primary responsibility for the conduct and safe management of restraint of patients in any healthcare setting. This should be part of NHS and police policy. In the absence of support from other agencies the police may have to intervene with some form of restraint, but its use should be strictly limited and subject to robust monitoring and training.
- There should be mandatory and accredited national training for police officers in restraint techniques, including de-escalation and supervision of vital signs during restraint, with appropriate refresher training for officers. There should be national consistency in approaches to the use of force.
- The grave dangers of prone and other forms of restraint in and of itself must be reiterated within forces in an effective manner and re-emphasised in training and re-training by all forces.
- ‘Excited Delirium’ should never be used as a term that, by itself, can be identified as the cause of death. The use of Excited Delirium as a term in guidance to police officers should also be avoided.
- Collaboration between pathologists, psychiatrists and emergency medicine practitioners is required to clarify and standardise the medical understanding around restraint-related deaths involving mental health crises. This should underpin future police training. An international conference and further urgent research is required to achieve consensus and better understanding.
- National policing policy, practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk.
- The restraint of anyone suffering a mental health crisis should be identified in national policy and training as a high risk strategy giving rise to a medical emergency. Where all else has failed or life threatening circumstances demand, it should be used for the very shortest time possible and an ambulance should be called for immediate transportation to Accident and Emergency.

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- A mandatory safety officer approach should be implemented by all police forces similar to that used in the prison setting.
 - Restraint equipment should be strictly limited and subject to robust monitoring and review. Its use should form part of the mandatory training.
 - Independent international research should be carried out to look more closely at the safety of Conductive Energy Devices.
 - CCTV should be introduced in police vans nationally to allow monitoring of restrained detainees, in conjunction with vigilant supervision of welfare and safety during transport. Failure to ensure its proper functioning should be a disciplinary issue. Unforeseen CCTV failures should not result in a van being taken out of service if a detainee requires urgent transportation.
 - The national 'use of force' data collection must be continually reviewed to ensure it provides the necessary transparency, auditing, active monitoring and opportunities for learning and training absent from the current system. Monitoring of ethnicity and mental health should be part of that system. More meaningful information should be requested from forms recording use of force.
 - There should be robust data collection on near misses and non-fatal serious incidents by the police and IPCC.

3. Intoxication

3. Intoxication

Introduction

- 3.1 According to IPCC figures, in 2014/15 of 17 people who died in or following police custody:
- “Sixteen people were known to have a link to alcohol and/or drugs in that they had recently consumed, were intoxicated from, were in possession of, or had known issues with drugs or alcohol at the time of their arrest. In six of these cases, a pathologist stated that alcohol or drug toxicity or long term abuse was likely to be a contributing factor in the cause of death.”*
- 3.2 In 2015/16 there was a similar pattern. According to the IPCC:
- “Twelve people were known to have a link to alcohol and/or drugs in that they had recently consumed, were intoxicated from, were in possession of, or had known issues with drugs or alcohol at the time of their arrest. Where cause of death was known, for six people a pathologist stated that alcohol or drug toxicity or long-term abuse was likely to be a contributing factor in their death.”²⁷*
- 3.3 During the 11 years 2004/05 – 2014/15, 82% of people who died in or following police custody had some link to alcohol and/or drugs. Overall, 49% of those who died had alcohol and/or drug related factors identified specifically as a cause of death in a post-mortem examination.²⁸
- 3.4 These figures highlight that drugs and alcohol remain a significant factor in deaths in police custody, and indicates that this is as much a public health issue as a policing issue. The adherence to policies designed to protect the health and safety of detainees is fundamental. The need to effectively implement observation regimes for severely intoxicated detainees is therefore of manifest importance.

Observation regimes

- 3.5 Police guidance on observation of detainees is set out in the College of Policing Authorised Professional Practice (APP) on Detainee Care²⁹. The guidance states:
- “Subject to medical direction, this is the minimum acceptable level for detainees who are under the influence of alcohol or drugs, or whose level of consciousness causes concern. It includes the following actions:*

27 Deaths During or Following Police Contact, Statistics for England and Wales, 2015/16, IPCC

28 Deaths in police custody: A review of the international evidence

29 <http://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/#observation>

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- *the detainee is visited and roused at least every 30 minutes physical visits and checks must be carried out – CCTV and other technologies can be used in support of this*
 - *the detainee is positively communicated with at frequent and irregular intervals*
 - *visits to the detainee are conducted in accordance with PACE Code C Annex H.”*
- 3.6 According to the submission to this review from INQUEST, non-compliance with observation procedures is ‘persistent, widespread, and identified repeatedly over time and across numerous police forces’. They provide evidence of a large number of cases in which Coroners and juries have made findings and cite several detailed case studies where failures to comply may have been a factor in the deaths. Inquests have identified failings by custody sergeants, other police officers, civilian detention staff, nursing staff and Forensic Medical Examiners.
- 3.7 The 2013 narrative conclusion of the Inquest into the 2009 death of Andrzej Rymarzak stated:
- “Andrew (sic) should have been subject to rousing checks due to the issues raised in the risk assessment. The custody sergeant should have ensured that the DDO30 was carrying out these rousing checks. It was a gross failure that the custody sergeant did not do this. The DDO had access to the risk assessment and should have carried out rousing checks. This was a gross failure by the DDO.”*
- 3.8 Another case was highlighted in the Coroner’s Prevention of Future Death report into the 2013 death of Neil Budziszewski, which stated:
- “The afternoon custody sergeant at Ecclesfield failed to place Mr Budziszewski on 30 minute rousing checks in breach of PACE Code C (paragraph 9.3). Indeed, there was no annotation on the custody record of the level of checks required.*
- “The afternoon civilian detention officer believed that Mr Budziszewski had been taken off rousing checks by 8pm because he had been in custody some five hours and rousing ‘was no longer necessary’. This seems to be a commonly made informal decision with no record made.”*
- 3.9 Finally, the 2016 narrative conclusion of the Inquest into the 2015 death of Istiak Yusuf stated:
- “There are clear errors and omissions in the way the cell observations were carried out. The key points are:*
- *Unsatisfactory training of detention officers*
 - *The ‘glance’ at 11:22am was inadequate and would not have been sufficient to see signs of life*

- *The 11:22am check should have been conducted earlier which may have shown Mr Yusuf to be convulsing and may have led to earlier medical intervention*
- *Use of a spy hole was not adequate and although it may have been Bedfordshire Police policy it contravened national guidance.”*

3.10 These, and other similar cases, demonstrate a need for a greater focus on this issue within force inspections and the HMIC inspection regime.

3.11 There have also been failures linked to mistaking serious medical conditions for intoxication, or when there is intoxication, failing to recognise that it may be masking other serious injuries or conditions. This was recognised by the IPCC as far back as 2008 in its report ‘Near Misses in Police Custody: a collaborative study with Forensic Medical Examiners in London’, which recommended:

“The message needs to be reinforced that apparent symptoms of intoxication may in fact be the result of an injury or medical condition, and that intoxication may mask or be found in conjunction with serious health needs.”³¹

3.12 There is also a tendency for some officers to consider that a detainee may be ‘faking’ a condition. However, police officers cannot afford to make such assumptions. It may lead to deterioration in a detainee’s condition going unnoticed, or indeed prove fatal. Alcohol withdrawal syndrome can also be life threatening and is discussed below.

3.13 An observation regime intended to safeguard such detainees is set out in the Police and Criminal Evidence Act (PACE) 1984 Code C paragraph 9.3 and Annex H. Code C paragraph 9.3 requires that:

“Those suspected of being under the influence of drink or drugs or both or of having swallowed drugs... or whose level of consciousness causes concern must, subject to any clinical directions given by the appropriate healthcare professional... :

- *be visited and roused at least every half hour;*
- *have their condition assessed as in Annex H;*
- *and clinical treatment arranged if appropriate.”*

3.14 Annex H of PACE sets out the requirements commonly known as the “4Rs” namely Rousability, Response to questions, Response to commands, Remember illness or injury:

“1. If any detainee fails to meet any of the following criteria, an appropriate healthcare professional or an ambulance must be called.

“2. When assessing the level of rousability, consider:

Rousability - can they be woken? • go into the cell • call their name • shake gently

31 <https://www.ipcc.gov.uk/page/near-misses-police-custody>

Response to questions - can they give appropriate answers to questions such as:

- *What's your name?*
- *Where do you live?*
- *Where do you think you are?*

Response to commands - can they respond appropriately to commands such as:

- *Open your eyes!*
- *Lift one arm, now the other arm!*

“3. Remember to take into account the possibility or presence of other illnesses, injury, or mental condition; a person who is drowsy and smells of alcohol may also have the following:

- *Diabetes*
- *Epilepsy*
- *Head injury*
- *Drug intoxication or overdose*
- *Stroke*”

3.15 A dossier of Inquest outcomes provided by INQUEST to this review, covering cases from 2007-2016, outlined failings identified by juries and Coroners at the conclusion of several inquests involving deaths of intoxicated detainees. Common findings include:

- failure to place the detainee on appropriate observation regime e.g. hourly rather than half hourly checks or checks carried out but not rousing checks
- checks not being carried out (including false records of checks e.g. where CCTV shows that checks recorded were not in fact conducted)
- inadequate rousing checks where no proper rousing takes place
- cursory checks carried out through the spyhole or cell hatch only
- over-reliance upon CCTV observation in place of actual visits to the cell
- lack of awareness by officers of how to assess levels of intoxication
- officers conducting observations failing to recognise when the detainee is in medical difficulties and delay in providing medical assistance
- failure to act on information gathered whilst checks conducted
- no system of allocated responsibility for conducting checks and custody officer failing to ensure that detention officers conduct checks
- widespread failure to implement observation regimes
- lack of clear guidance and understanding by officers about the operation of observation regimes, including up to rank of custody sergeant
- staffing levels insufficient to maintain compliance
- delay in opening cell door to give urgent medical care by officer conducting constant observation due to lack of availability of keys
- unsatisfactory training on observation regimes

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- 3.16 Where individuals are acutely intoxicated their circumstances may be life threatening. The volatile, hectic environment of a police station does not provide an appropriate, overarching location to monitor vital signs and custody officers may be subject to multiple, competing demands. In such environments CCTV may not always be the safest or most effective way to monitor detainees. Members of the Police Federation told this review that a small screen split four ways was of little use. They are simply not resourced enough to be able to watch all CCTV images all of the time – and even then officers may conduct other duties while the images are being watched.³²

“Where individuals are acutely intoxicated their circumstances may be life threatening.”

- 3.17 The development of vital sign technology such as pulse oximeters (used to measure heart rate and oxygen intake) or other wearable technology may also be of increasing assistance in the future but is not yet a substitute for effective observations and a checking regime.

‘Drying out’ Centres

- 3.18 ‘Drying out’ centres are a potential alternative to police custody and Accident and Emergency Departments for those who are under the influence of drink and/or drugs and require specialist supervision. They are widely used in Australia³³, and have the potential to reduce deaths in police stations. Specialist staff and on-site healthcare workers are potentially better able to give the care and observation that police custody staff may not be able to give. This is not to traduce the ability of custody officers, some with many years of experience, to properly care for and monitor intoxicated detainees, but in a chaotic environment police resources may be stretched.

32 see McKinnon, Thorp and Grubin (2015) “Improving the detection of detainees with suspected intellectual and disability in police custody”, Vol.9 ISS 4 pp.174-185

33 Deaths in police custody: A review of the international evidence

3.19 In addition, many intoxicated detainees will not have been arrested for serious offences that would require police detention. Data collected by the IPCC show that nearly one fifth (19%) of those who died during the 11 years 2004/05 – 2014/15 were arrested for drug/ drink related offences. Just over half of these offences were for drinking (i.e. non-notifiable) offences.³⁴ Instances of being ‘drunk and disorderly’ or for committing minor public order offences would be better dealt with through drying out centres. This could relieve a strain on police resources and allow diversion from prosecution of those who attend the drying out centres for non-notifiable offences.

3.20 Police guidelines state that the most severely intoxicated people should be taken to hospital. For example, paragraph 4.38 of the Metropolitan Police Custody Standard Operating Procedure states:

“Alcoholic intoxication is a form of poisoning. If the person cannot walk unaided or talk coherently, on entering the custody suite or at any time during the detention, or if they record 150 or more on the EBM, they must be treated as a medical emergency and be taken to hospital by ambulance.”³⁵

3.21 However A&E departments may be reluctant to receive intoxicated detainees as there may be a perception and experience that such patients are ‘difficult’ and dangerous to deal with. Drying out centres would provide an alternative option for the police to take an intoxicated detainee, and relieve pressure on hospital staff. Such centres may be linked to the A&E department or situated close by.

3.22 In large urban areas sufficient numbers of intoxicated detainees may make ‘drying out’ centres cost effective if the resulting savings from policing and medical services were taken into account. However, it should be recognised that a debate about such facilities has been going on since the 1980s. In written evidence to this submission INQUEST gave some historical context:

““Out of Court” was an umbrella group of over 20 organisations including Association of Chief Police Officers, Association of Chief Probation Officers and Prison Officers’ Association working for “realistic alternatives to the processing of drunkenness offenders through the criminal justice system”. They noted that in 1983 in London 12 of the 18 people who died in police custody were arrested for drunkenness and that between 1970 and 1979 of a total of 274 deaths in police custody 95 were attributed to alcohol or drugs. Their proposal was that “the Home Office will now realise that police cells should not be used for drying out offenders and that it will provide pump priming money at local level to support the establishment of services for these people”.

“Two pilot detoxification centres were funded in Leeds and Manchester accepting intoxicated offenders from the police and offering medical care. However the Government considered the centres too expensive and Douglas Hurd announced the withdrawal of Home Office funding from detoxification centres on 20 November 1985.”

34 Deaths in police custody: A review of the international evidence

35 http://www.met.police.uk/foi/pdfs/disclosure_2014/november_2014/2013060001416.pdf

3.23 In addition, a Metropolitan Police Authority report Lessons From Tragedies, March 2002, made the following observation:

“The MPS has been engaged in discussions to develop the concept of alternative detoxification facilities based around Westminster since 1998. Initially plans were examined to build a new detoxification centre with inclusive medical facilities. The work hit problems around the high costs of developing such a facility in Central London and the associated running costs.”³⁶

3.24 There is consequently nothing new about the desire for purpose built detoxification or drying out centres. And each time they appear to have foundered because of cost. The Government need to determine whether the immediate costs of establishing such facilities are indeed offset by potential savings elsewhere and the opportunity to avoid further deaths or whether the design of A&E Departments need to be adapted to deal with these patients through the provision of specific space and staff able to accommodate and cope with the nature of the behaviour of their severe intoxication.

Denial of healthcare to intoxicated detainees

3.25 Mental healthcare facilities may refuse to accept people detained under section 136 of the Mental Health Act 1983 if they are intoxicated. This is potentially dangerous, given that such patients are at their most vulnerable, and may be suffering from mental ill health brought on by their intoxication. Without proper medical assessment it is not always obvious if there is a serious medical condition over and above the intoxication.

3.26 This issue was recognised by the Police Federation in evidence to this review:

“Drugs and alcohol are particularly challenging when combined with other issues and vulnerabilities, including both physical and mental ill health. The experience of our members is that, frequently, partner agencies such as the NHS are reluctant to take responsibility for those individuals who may have an underlying condition in need of treatment but who present as impaired or intoxicated.”

3.27 An example is the case of Tony Davis, who died in 2004 of hypothermia in a police cell after he was arrested for being drunk and incapable instead of being taken to hospital by ambulance. The Rule 43 report from the Coroner following the Inquest stated that:

“Evidence was given at the inquest by two police constables and a police superintendent that the ambulance service will not attend and that hospitals will not admit persons who are drunk and incapable, unless it is suspected that the person concerned has sustained some injury or trauma. Dorset Police provided copies of correspondence with the Strategic Health Authority requesting that a protocol be established so that such persons were not admitted to cells as a first resort. The Strategic Health Authority advised that they did not have the funding and expressed

36 <http://policeauthority.org/metropolitan/committees/x-cdo/2002/020314/07/index.html>

the hope that intoxicated persons would not be brought to any Accident and Emergency Department unless they had a medical need.”

- 3.28 This case demonstrates how a Strategic Health Authority was able to advise against bringing intoxicated detainees to hospital, unless in an emergency. It is not simply a judgement made by staff on the ground.
- 3.29 This may be because of a belief by some public services that acute intoxication alone does not present a serious medical danger, and the view, consciously or otherwise that severely intoxicated patients may be less deserving. For many years medical staff in A&E departments have been subjected to verbal and physical abuse by individuals who attend the hospital in an intoxicated condition.
- 3.30 However, it must also be recognised that healthcare workers and NHS Trusts have a duty of care to all their patients. Intoxicated patients can be very challenging for stretched and chaotic A&E departments, and can be disruptive and dangerous for nursing staff. Whilst the police should also not be subject to violent attacks, it is nonetheless true that police officers are trained specifically to deal with violent people in a way that healthcare staff are not (although they now have trained security staff to assist).
- 3.31 Drying out centres would require suitably trained security staff to assist medical staff. They would also reduce the frequency with which other vulnerable patients or members of the public are put at risk or distressed in A&E facilities. The alternative would be to consider the complete redesign of A&E facilities to humanely isolate intoxicated disruptive and aggressive patients, and give them the proper medical attention they need in a more secure environment.
- 3.32 Currently, the Care Crisis Concordat states that:
- “People intoxicated as a result of alcohol or drug misuse who have been assessed as mentally disordered or are currently being treated by a mental health service will be accepted into the designated health based place of safety.*
- “People intoxicated as a result of alcohol or drug misuse who do not appear to be mentally disordered or who are not known at a mental health service will be dealt with by the police through criminal justice processes.”*
- 3.33 There should be joint protocols in place, including co-ordinated guidance and training between police forces, NHS Trusts and public services (such as drying out centres) in order to have greater clarity about how best to deal with intoxicated individuals and who is ultimately responsible for their care. Some forces may already have such arrangements in place, as this is also recommended by the College of Policing Authorised Professional Practise on Alcohol and Drugs which states:
- “Forces should agree a protocol with local healthcare agencies for dealing with people who are drunk and incapable.”³⁷*

37 <https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/alcohol-and-drugs/>

Alcohol withdrawal

- 3.34 Police Federation members who gave evidence to this review expressed the opinion that alcohol withdrawal is the worst condition police officers have to face, and can lead to panic when it occurs. When an alcoholic begins to go into withdrawal, the body creates anti-toxins in anticipation of alcohol. When the alcohol is not forthcoming the anti-toxins become toxic and attack the body.
- 3.35 Medical advice is clear that alcohol withdrawal is life threatening – something that has been confirmed in various Inquest conclusions. This is also confirmed by the College of Policing Authorised Professional Practise on Alcohol and Drugs which states:

“The detainee may also have consumed alcohol or be experiencing alcohol withdrawal which, in addition to complicating other presenting signs and symptoms, carries a significantly increased risk of morbidity and mortality if left untreated...detainees should be able to stand and walk unaided and say a few words. If not, they should be transferred to hospital rather than being put in a cell.”

Training on intoxication

- 3.36 A dossier of Inquest outcomes provided by INQUEST to this review relate to intoxication and disclose common findings based on a systematic review of cases over 9 years:
- failure to recognise that a serious medical condition can be mistaken for intoxication and that intoxication can mask other serious medical conditions or injury
 - intoxicated people are placed in police custody when they should be in a healthcare environment
 - ambulance service and A&E refuse to assist intoxicated people unless there is also some other medical condition
 - insufficient training and awareness by officers of the dangers of intoxication
 - failure to recognise that alcohol withdrawal syndrome can be life threatening
 - failure to recognise decreased levels of consciousness and dangers associated with deterioration in consciousness
 - failure to recognise the risk of positional or postural asphyxia where reduced consciousness may obstruct the airway and the danger of obstruction of the airway by tongue or vomit

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- 3.37 It is clear from Inquest findings over many years that consistent, mandatory training on issues relating to detainee vulnerability is essential. It should have medical input where necessary and be made available to all relevant staff, including people employed by private service providers. There is currently no oversight body or framework to monitor the provision of such training. The possibility of a national framework to embed learning is discussed in more detail in Chapter 17 (Sustained Learning).
- 3.38 The need for a wider role by the NHS and healthcare provision within police stations may go some way to addressing some of these issues and is discussed in more detail in Chapter 11 (Police Custody: Medical Care, Inspections and External Agencies).
- 3.39 There may also be a need to consider new ways of thinking for diverting people from police contact, and for considering health based responses to drug and alcohol misuse. For example, Glasgow City Council is actively considering 'self-injection' rooms for drug users to inject safely and under supervision. The proposal has been supported in principle by several agencies in Glasgow including the police. Bold thinking and localised approaches could lead to positive interventions for vulnerable people.

Recommendations:

- HMIC should include a focus on inspection of observation regimes for intoxicated detainees within its Expectations of Police Custody (updated April 2016). HMIC should monitor police forces' internal inspection procedures for observation regimes.
- The Government should give consideration to the viability and cost-effectiveness of drying out centres, and consider piloting a centre or centres in large urban areas where it is most likely to be cost-effective, and linking such centres to existing A&E departments. An alternative would be the fundamental redesign of A&E departments to take into account this challenging situation.
- An NHS initiative at the national level should examine whether to prohibit the refusal of access to A&E or to health-based places of safety under section 136 Mental Health Act 1983 (section 136) on the basis of intoxication. It should also consider the redesign of A&E facilities to allow for safe areas, to protect the safety of other routine patients and staff from those suffering from intoxication.
- Joint local protocols should be established between police forces, ambulance services and hospitals to ensure appropriate medical care for intoxicated people in the appropriate environment.
- Comprehensive and standardised mandatory police training is required across forces for custody sergeants, officers and civilian detention staff on the dangers associated with intoxication. This should include medical input.
- Training for privatised detention and medical services must be to the same standard as for police staff and include joint training with custody sergeants and other officers working in the custody environment. Joint training is also required for Forensic Medical Examiners and custody sergeants.

4. Mental Health

4. Mental Health

Introduction

- 4.1 The issue of mental ill health manifests itself time and again within the police custody context. Frequently, police officers find themselves as the first point of emergency contact for those suffering from mental ill health. The first instinct of most members of the public witnessing such an episode is usually to call the police to deal with the individual because of the disturbed or disorderly nature of their behaviour. Even families may call the police rather than an ambulance where they consider their loved one's behaviour may result in injury or danger and is beyond their ability to cope.
- 4.2 Certain characteristics commonly feature in cases of death involving mental ill health in the police custody context. These include the ability of police officers to recognise and interpret symptoms of mental ill health, rather than attributing disturbed behaviour to drunkenness or drug abuse (although some forms of mental ill health may be triggered by stimulants such as cocaine or so called legal highs). In such cases there may also be discriminatory fears in the mind of police officers and healthcare workers about the nature of the individual they have been called to deal with – the perception of 'mad, bad and dangerous' detainees. Police officers often describe a detainee as having superhuman strength, or being the biggest man they had ever seen, whereas in reality the detainee may have only been of average size. This highlights the way that perceptions may be borne out of or affected by chaotic and often frightening situations.
- 4.3 Such fears may result in the police officers commanding the individual to comply immediately with their instructions, such as shouting repeatedly, "get down on the ground". Where an individual is suffering from an acute behavioural disturbance they are often unlikely to respond rationally, if at all, to such commands. Attempts by officers at de-escalating the conduct by trying to calm and soothe the individual or contain their movement within a reasonable space do not always occur or are often abandoned prematurely with prolonged attempts at physical restraint then ensuing.
- 4.4 These episodes may represent acute medical emergencies – but often they are not treated or understood as such. One family who spoke to this review told of how the police ignored pleas to take their son to hospital, and how they put him in the back of a police van instead:

"I was there during the day, he was behaving strangely. I was there at the end. He was restrained and put in the back of the van which was far too small for him. They did not take any notice of me. I asked them to take him to hospital. They did not even pass on the information about him not eating, sleeping."

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- 4.5 Once physically restrained there is often insufficient or no appreciation of the acute medical vulnerability of the detainee and no focus by officers on the need to divert immediately such individuals away from police custody to appropriate emergency health facilities. This may be as a result of prioritising the disorderly criminal conduct, concern about public safety and because of the struggle against arrest that may have resulted in injury of an officer or at least deep frustration, fear or exasperation. Officers may also consider that the local health facilities may not accept the individual because of intoxication.
- 4.6 There are therefore also occasions where detainees are held in police stations under section 136 of the Mental Health Act 1983, rather than at a health based ‘place of safety’. This may involve potentially dangerous transportation in police vehicles rather than in ambulances and places an onus on the police to care for someone in an environment that is wholly unsuitable for detainees with acute mental ill health. The use of police vehicles for transporting people detained under section 136 should be stopped in all but the most exceptional of situations. These are health emergencies (particularly where force has been used) and an ambulance should be summoned for all section 136 detainees. Detainees can be carefully restrained on stretchers before being placed in the ambulance by trained staff, which is preferable to transfer in wholly unsuitable and unsafe police vehicles.
- 4.7 The detention of the individual in a police cell is also unsuited to the danger the detainee may present to himself/herself and to police officers there. Under the Equality Act 2010, there is a requirement to facilitate all requests for reasonable adjustments as far as possible to accommodate the needs of disabled people (the Act defines a disabled person as having ‘a physical or mental impairment’.³⁸) This obligation is recognised by the College of Policing in its Authorised Professional Practice on Equality and individual needs.³⁹ This requirement can only be met if detainees are in a position to make such a request, and if the police are adequately resourced to facilitate it.
- 4.8 Several inquests over many years have highlighted the inadequate police training in or implementation of safe restraint techniques. Similarly, a failure to recognise the behaviour as the manifestation of mental ill health or drug induced mania, and thus a real medical emergency, are all too common in many of the deaths over many years.
- 4.9 The narrative verdict of the 2012 inquest into the death of Sean Rigg stated:
- “The police failed to identify that Sean Rigg was a vulnerable person at the point of arrest and he was therefore taken back to the police station instead of an Accident and Emergency department or Section 136 Suite, despite information about him being readily available and accessible...there was a failure to secure an ambulance as quickly as possible.”*

38 <http://www.legislation.gov.uk/ukpga/2010/15/part/2/chapter/1>

39 <https://www.app.college.police.uk/app-content/detention-and-custody-2/detainee-care/equality-and-individual-needs/#disabled-detainees>

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- 4.10 The need for consistent national training for the police on dealing with mental ill health is of utmost importance. There is general agreement in the submissions to this review that dealing with mental ill health has become a major part of daily policing both with victims and suspects.
- 4.11 The issue of mental ill health is of great concern for families of the deceased and their supporters. There are several examples of deaths in police custody, or where the police were present, involving people suffering from mental ill health issues. These are often some of the most contentious cases, which often necessitate prolonged and difficult investigations. Although each case is an individual tragedy, there are similarities. Most of these cases involve some use of force and restraint where the focus and determination to physically restrain is at the expense of any awareness or concern for the dangerousness of the situation and the vulnerability of the detainee to positional asphyxiation and/or sudden death. There have also been many failures in the overall care of vulnerable detainees once detained in crowded, volatile and busy cell areas of a police station.
- 4.12 There have been significant recorded increases in the number of people with mental ill health coming into contact with the police. Research by the Guardian in January 2016 suggested that “UK police are spending as much as 40% of their time dealing with incidents triggered by some kind of mental health issue”.⁴⁰ The Inquest Lawyers Group, in written evidence to this review stated:
- “As cuts impact and local public services are withdrawn, the police increasingly become the first point of contact in the community for those in acute mental health need. Policing practices must change to reflect this changing profile of police work, to prevent the further unnecessary loss of life.”*
- 4.13 As INQUEST identified in its submission to the Home Affairs Committee (HAC) Inquiry into Policing and Mental Health in May 2014⁴¹:
- “The fact that nearly half of police-related deaths now involve people with mental illness is evidence that policing on the ground is failing to recognise or adequately adjust to the changing nature of this policing demand. This is borne out by evidence across INQUEST’s case work which shows near identical issues and problems arising. Many of these issues are not new and have been well documented as a result of previous deaths. It is a tragic fact that deaths are arising as a result of the failure to act on this important evidence base. As many of the families have said, their loved ones have not died as a result of ‘mental health’ but as a direct result of the way in which they were treated, in many cases as a result of the dangerous and excessive use of restraint.”*

40 <https://www.theguardian.com/uk-news/2016/jan/27/mental-health-crisis-huge-increasing-share-police-time-40>

41 http://inquest.org.uk/pdf/briefings/INQUEST_HASC_policing_and_mental_health_submission_FINAL_May_2014.pdf

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- 4.14 The IPCC statistics on deaths in police custody demonstrate a considerable proportion of deaths involving people with mental health needs. Figures published for 2014/15 show that nearly half (eight out of 17) of those who died in or following police custody were identified as having mental health concerns. In 2015/16 the figure was exactly half (seven out of 14)⁴². Figures published for the last five years consistently show nearly half (46%) of those who died in or following police custody were identified as having mental health concerns.
- 4.15 Following campaigning from bereaved families, including those of Sean Rigg and Olaseni Lewis, the Metropolitan Police Service established the Independent Commission on Mental Health and Policing, chaired by Lord Victor Adebowale. The report of the Commission was published in May 2013, and set out 28 recommendations⁴³. The Home Affairs Committee (HAC) also published a report on policing and mental health in February 2015 with its own recommendations⁴⁴.
- 4.16 The HAC report estimated that between 20% and 40% of police time involves dealing with some form of mental health issue. There is a view that this is as a result of a general deterioration in mental health services which has left the police effectively the 'service of last resort'. This results in a belief by some officers that they are being forced to take on a healthcare role that they are not sufficiently trained for, and is not part of their job description⁴⁵.
- 4.17 According to Professor Louis Appleby (University of Manchester) there is a counterview that the rise of the use of Section 136 coincided with a time when there were big increases in resources for mental health crisis teams between 2004-07. Therefore, any rise in the use of section 136 was not originally driven by a lack of resources, but by increased awareness of mental health issues.
- 4.18 Irrespective of the reasons for the increased use of section 136, there is an urgent need to ensure that all police officers are trained and competent in recognising and dealing with the most common symptoms of mental ill health or disability in those victims and suspects with whom they engage. They must also be confident and competent in the use of de-escalation and calming techniques which when deployed in many instances can help subdue those suffering from hallucinations until emergency ambulance personnel arrive.
- 4.19 However, this does not mean that police officers should never take responsibility for dealing with mental ill health. If someone dies in custody then there may have been an urgent need for medical care that was missed. However, according to expert medical opinion given to this review, it is too simplistic to argue that the use of police cells to care for mentally ill people can be solely attributed to inadequate health services. It

42 IPCC annual statistics 2015/16

43 http://www.turning-point.co.uk/media/621030/independent_commission_on_mental_health_and_policing_main_report.pdf

44 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf>

45 HAC para 5

has never been the responsibility of healthcare services to look after less severe cases of personality disorder, for example and there may be individuals with mental ill health who do not require to be admitted to an acute medical facility. The police need to be properly trained to deal with ill people. In the words of Lord Adebowale, ‘mental health is part of the core business of policing’.⁴⁶

Modern policing and mental health

- 4.20 It should be recognised that policing today is hugely complex, with officers expected to take on a wide range of roles and have competence in issues not demanded of their predecessors. Even excluding those with mental health issues of great severity there remain many thousands suffering from mental health issues that do not require emergency attention or admission, as well as victims and witnesses requiring a much greater understanding of their vulnerability.
- 4.21 The police, for example, often have to deal with people suffering from a personality disorder. Many such people are not suffering from a severe illness that would require admittance to a hospital or healthcare facility, but their needs and vulnerabilities are very real. They usually also suffer from anxieties and depression brought on by trauma and developmental issues. They can display aggressive and volatile behaviours. Many self-medicate such illnesses with alcohol or drugs. Such enduring behaviours often put them at risk. It is subsequently a very difficult condition to treat, and mental health services can be reluctant to help them because of this.
- 4.22 While it is to be welcomed that police stations will no longer be designated as ‘places of safety’ under the Mental Health Act 1983, it should be recognised that inevitably many people with mental ill health will pass through police stations and police custody at some point both as victims and witnesses and as the accused. Therefore the police need to be geared up to deal with these challenges. The perception of what a police station is and does also needs to change. As Professor Louis Appleby told this review, if all the people with mental health issues were removed from police custody there would almost be no need for police custody suites to exist.
- 4.23 While diversion away from custody and the courts is desirable where possible, for many accused and others the seriousness of the alleged crime requires the case to be dealt with in the Criminal Justice System. This situation still demands a greater crossover of skills among police and healthcare professionals and greater flexibility in responses. The Courts are also moving to a greater problem solving approach to address criminal behaviour with greater sophistry and insight than was permitted in previous years.

The inappropriateness of police custody

- 4.24 There is a general recognition that police stations are not appropriate places of safety for those suffering from an acute mental health crisis. However, a determined effort to adopt appropriate safeguards and procedures can minimise risk. For example, as INQUEST acknowledged in written evidence to this review:

“There has been a drastic reduction in self-inflicted deaths within police stations. This appears to be the result of the application of custody procedures to safeguard potentially suicidal detainees, and steps such as the removal of ligature points which must continue to be applied rigorously to prevent deaths and incidents of self-harm.”

“Police stations are not appropriate places of safety for those suffering from an acute mental health crisis.”

- 4.25 The annual IPCC report *Deaths during or following police contact* for 2015/16 gives further context to this:

“This year no one died after making an apparent suicide attempt while being held in police custody. Since 2004/05, six people are known to have made a fatal suicide attempt in a police cell. The last incident was in 2014/15, and before that in 2008/09.”

- 4.26 This is hugely significant, as it demonstrates that progress is possible, and the police custody environment can become a safer place. We should not be complacent however. In November 2014 a vulnerable woman, Martine Brandon, took her own life in a police cell, the first such death since 2008/09.

*“**Martine Brandon:** Martine was detained in Southampton Police Station despite clear indications that she was suffering a mental health crisis. An inquest jury found that Martine had been caused avoidable distress having been left in her own faeces for six hours, and by the fact that communication with her by custody staff had been inadequate. The custody record claimed that Martine was breathing and asleep on the bench, at a time when she lay unresponsive on the floor of her cell. The jury found that she took her own life having removed and swallowed her underwear”⁴⁷*

- 4.27 Whilst suicides within police custody have declined dramatically, since 2012/13 there has been a spike in the recorded numbers of apparent suicide within two days of a person being freed from police custody. There should therefore be a particular focus on addressing the needs of potentially suicidal people upon release.

47 INQUEST case study.

4.28 Appropriate alternatives to police custody will invariably depend upon the requirements of the individual, it being recognised that symptoms of a mental health crisis will manifest themselves in different ways. In the opinion of *NHS Providers*⁴⁸ in written evidence to this review, Accident and Emergency care is the best place of safety for those exhibiting acute mental and physical problems.

Mental health training

4.29 In written evidence to this review the Police Federation stated:

“Dealing with those in our communities who are suffering with mental ill health problems is considered as core police business. Police officers and staff working in public-facing roles, in particular those working with detained persons, require improved, accredited and consistent training and development in the identification and management of mental health risks; we believe that this should be a mandatory requirement for all officers.”

4.30 In its submission to the HAC on Mental Health and Policing, INQUEST highlighted training needs on mental health:

“Common to most cases is poor understanding of mental health and all but the most minimal training around mental health issues. This is impacting at all stages in the policing process: from the moment 999 calls are made by members of the public (with decisions around call logging and level of urgency) through to arrest and detention. A full understanding of where things are going wrong is needed to inform the change needed to training. A detailed look at the issues and learning from recent deaths would provide a valuable source for identifying gaps and problems.

“Disturbingly, a recent national custody survey of police inspectors (conducted by the Inspectors’ Central Committee of the Police Federation of England and Wales over the period 21 October to 22 November 2013) identified that 76% of the 746 respondents had not received training in dealing with the mentally ill in custody.

“Central to the implementation of any change on the ground is the need for more and better training around mental health. Training must be regular enough to ensure sustained learning and to ensure emerging and better practice is incorporated into day to day policing. Historically, some police forces engaged the help of mental health service users in their mental health training. INQUEST’s view is that this must be re-introduced to enable a better understanding of the issues and to help break down some of the fears and assumptions that may be informing poor practice.”

48 The membership organisation and trade association for the NHS acute, ambulance, community and mental health services

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- 4.31 Since the death of Roger Sylvester in 1999 there have been many reports looking at mental health training. These include the MPS Restraint and Mental Health Review, 2004; the Bradley Report, 2009; ACPO/NPIA Guidance on Responding to People with Mental Ill health or Learning Disabilities; 2010; the Adebowale Report, 2013; the Bradley Commission Report, 2014; Home Affairs Committee on Policing and Mental Health, 2015; the College of Policing draft APP on Mental Health, 2016; and the conclusions of various inquests. These reports have all called for increased and improved training in mental health training within the police service. However, progress has tended to be slow, not sustained, fragmented and with little national coordination.
- 4.32 In oral evidence to this review, Michael Brown, the national mental health coordinator for the College of Policing, agreed that there was an emerging sense that the police need to see themselves as mental health professionals, but that training remained ‘patchy’. He also believed that there was a lack of interest from police forces in having more than one day of training per year, although the College believes that more is required. New police recruits may only get six hours training in mental health awareness before graduation.
- 4.33 As a result, there appears to be a pressing need for a national mechanism that can monitor if and when police forces are carrying out training recommended by the College of Policing. This idea is explored further in Chapter 17 (Sustained Learning).

Removing mentally ill people from the policing context

- 4.34 Many people who come into contact with the police and are suffering from mental ill health may be arrested for criminal offences and taken to police stations rather than a health based place of safety. As has already been stated, in cases where there has been serious criminal wrongdoing this approach may be warranted. However, for more minor offences, healthcare should be a priority where there is an acute need. Even in serious cases the mental fitness of an accused person to be interviewed or detained may require an urgent medical assessment.
- 4.35 In written evidence to this review, lawyers from Doughty Street Chambers stated:
- “A proportionate policing response should be rooted in an understanding that the police are not the best professionals to deal with those suffering from mental ill health and experiencing mental health crisis. Officers should approach first contact situations with a firm understanding that those experiencing mental health crisis require medical care and specialist services, and that a conventional policing response will not address the or resolve the situation.”*
- 4.36 As a general principle, this should apply, although as has already been discussed in this chapter, the police still have a responsibility to handle non-critical, less acute displays of mental ill health from members of the public.

4.37 The necessary communication, de-escalation and diversion required to prevent unwell detainees being detained by the police requires multi-agency cooperation and a clear understanding of the roles, responsibilities and skill sets of the police and healthcare bodies.

4.38 As one submission to the public consultation for this review noted:

“In an advanced, prosperous country people with mental disorder should receive their care from the health services and not from the police. The mental health services need to be sufficiently resourced, in terms of funding, facilities and manpower, to enable them to provide a comprehensive service, to be able to stop rationing their services on spurious grounds leaving often the most disturbed, vulnerable and deserving to fall through the cracks between their rigidly ring-fenced teams with only the police to catch them.”

Arresting for criminal offences rather than section 136 of the Mental Health Act 1983

4.39 ACPO/NPIA⁴⁹ *Guidance on Responding to People with Mental Ill Health or Learning Disabilities, 2010*, and the MPS *Standard Operating Procedure on Policing Mental Health*⁵⁰ cover the issue of ‘dual arrests’, whereby someone may be detained under section 136 and for criminal offences⁵¹. These state that if a criminal offence is trivial, such as for a minor public order offence related to mental ill health, then the individual should be detained under section 136 and taken to a health-based ‘place of safety’.

4.40 Where offending is more serious, a dual arrest under both section 136 and for the criminal offence should be made, with the suspect taken to a police station where the criminal matter can be dealt with while a mental health assessment is arranged. Once the investigation has concluded, the detainee can be transferred to a suitable place of safety using section 136.

4.41 This means that there can be arrests for serious criminal offences of people who have been suffering from an acute mental health crisis. If a person requires an urgent mental health assessment this should take precedence over any criminal investigation in order to ensure the preservation of life, and to ensure the individual is fit to be interviewed, and any answers provided to police are admissible in evidence at any subsequent trial.

49 Association of Chief Police Officers / National Policing Improvement Agency

50 Version 4

51 Para 6.4.4.1 page 100

Detention under section 136 in the police station as a ‘place of safety’

4.42 In the past, concerns have been raised by campaigners about shortcomings in the application of section 136 by police officers. These have been summarised by INQUEST as follows:

- lack of effective policies and systems concerning the operation of section 136, for example, there is currently no clear policing process that applies from the moment someone is detained under section 136;
- poor training and understanding concerning the application of section 136 powers;
- the inappropriate use of police stations as suitable ‘places of safety’;
- conflicts and tensions between the NHS and police in the understanding of roles and responsibilities in the operation of section 136;
- local section 136 policies which fall short of Home Office guidance;
- overly restrictive local policies by NHS services concerning disturbed and agitated detainees, despite this being a common feature of someone in need of section 136 assistance;
- shortages of NHS ‘places of safety’ accommodation provision;
- lack of joint co-ordination and working between the relevant local agencies including to identify and address any emerging problems around the operation of section 136.

4.43 The use of police cells for those detained under section 136 remains a concern, as the following case studies illustrate:

“Toni Speck: *Toni was stopped by police officers in York in June 2011 after concerns were raised by a member of the public about her behaviour. She was detained under section 136 and taken to a police station where she was strip searched. She was later found collapsed in her cell, requiring urgent hospital attention, and died.”*

“Terry Smith: *In November 2013 Terry’s family called for an ambulance as he was behaving in an agitated and paranoid manner and they were concerned for his well-being. He ran outside in his underwear and was restrained by several police officers. He was detained under section 136 and taken to Staines police station where he was allegedly also arrested for possession of drugs. He remained in restraints and was carried straight into a cell where he continued to be restrained by officers for an hour and a half. He was then carried into an ambulance where he lost consciousness and subsequently died in hospital.”*

“Leon Briggs: *In November 2013 a concerned member of the public called for an ambulance regarding a man behaving oddly. Bedfordshire Police officers arrived, restrained Leon on the street and detained him under section 136 of the Mental Health Act. He was conveyed to Luton Police Station by the police and during the course of*

his restraint at the police station he became unresponsive. An ambulance was called and he was taken to hospital where he was pronounced dead.

4.44 Section 135 of the Mental Health Act 1983 designates a number of locations as ‘places of safety’. These include: **“accommodation provided by social services, a hospital, a police station, an independent hospital or care home for mentally disordered persons”**, as well as **“any other suitable place the occupier of which is willing temporarily to receive the patient”**. This means that even when police stations are removed from the list there would still be the possibility they could fall under this last definition, especially as a police station may be the only facility open in the early hours of the morning.

4.45 But there has been significant change in the last decade. In written evidence to this review, INQUEST stated that:

“A study in 2005/06 found 11,000 detentions in police stations and 5,500 in hospital⁵². By 2011/12 there had been a reversal with a greater number detained in health-care settings (9,000 police stations, 16,000 health-based) with the proportion in health-care settings increasing steadily (2012/13: 7,761 police and 15,073 health-based, 2013/14: 6,028 police and 18,461 health-based)⁵³. The Crisis Care Concordat of February 2014 commits the Government to a 50% reduction over two years compared with 2011/12 figures.”

4.46 Despite the welcome target of the Crisis Care Concordat that has been achieved, there are still thousands of detainees being taken to police stations. Figures for 2015/16 indicate that of 28,271 detentions under section 136 in England and Wales, 2,100 were to police stations (7%, compared to 19% in 2013/14).⁵⁴ £15 million was announced by the Government in May 2016 to help fund more health-based ‘places of safety’. However, it is also the case that individuals with mental illness are being arrested instead of using section 136. As Michael Brown, the national mental health coordinator for the College of Policing, stated in his blog⁵⁵:

“...there are many situations in which someone with a mental illness encounters the police and where the MHA power would not be the only one available. Very often it may be possible to arrest for a criminal offence or detain the person to prevent a Breach of the Peace.”

52 Dorking et al 2008 – quoted page 5 of Royal College of Psychiatrists Standards on the Use of Section 136 Mental Health Act, July 2011

53 HAC report on Policing and Mental Health, para 8

54 <http://cdn.prgloo.com/media/8258bofa33d341908dae6875d835dfo6.pdf>

55 <https://mentalhealthcop.wordpress.com/2016/07/16/correct-use-of-section-136/>

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- 4.47 Restraint-related deaths still occur in police custody, or other settings with police involvement. However, such deaths are virtually unknown in mental health detention settings when there is no police involvement. This may be because restraint can be managed differently in a mental health setting. There is easier access to rapid tranquilisation medication, and by definition staff are likely to have the specific skills set and experience for dealing with a mental health crisis. This is another illustration of why the use of health based places of safety can be an important way to minimise deaths and serious incidents.
- 4.48 It should also be noted that a patient detained under any other provisions of the Mental Health Act 1983 displaying disturbed or erratic behaviour would not be taken to a police station. The multi-agency group led by the Royal College of Psychiatrists⁵⁶, and endorsed by a range of medical bodies⁵⁷, wrote a 2011 report explicitly endorsing the use of health-based ‘places of safety’ for those exhibiting disturbed behaviour.
- 4.49 Despite the welcome downward trend in referrals to police stations, the provision in the Mental Health Act 1983 to allow for ‘any other suitable place’ to be used as a place of safety current guidance, creates a loophole that allows ‘difficult’ detainees be taken to police stations. This may result in detainees with a ‘history’ being denied access to a health based place of safety. The 2013 report, “A Criminal Use of Police Cells”⁵⁸ observed:
- “If a detained person were deemed to be violent, he or she would be more likely to be taken into police custody than to an alternative place of safety. Significantly, however, this did not mean that, in all cases reviewed, either the individual posed an immediate risk to themselves or to others, or that he or she required a greater level of security and containment than could be safely provided at a hospital. In at least one force area, health organisations would not admit anyone who was escorted to the place of safety in handcuffs or who had a history of violence, either on their health records or on a police record.”*
- 4.50 Ideally, those people detained under section 136 should be taken to a health-based ‘place of safety’ even if they are displaying disturbed behaviour that is very difficult to manage, as this could potentially help to prevent fatalities for the reasons outlined in paragraph 4.41.

56 Royal College of Psychiatrists Standards on the Use of Section 136 Mental Health Act, July 2011
<http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf>

57 NHS Ambulance Chief Executive Group, Care Quality Commission, College of Emergency Medicine, College of Social Work, Faculty of Forensic and Legal Medicine, Mental Health Network of the NHS Confederation, Royal College of Nursing

58 <https://www.justiceinspectrates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf>

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- 4.51 Police guidance on individuals exhibiting Acute Behavioural Disturbance is that these conditions are a medical emergency that require immediate referral to Accident and Emergency services by ambulance. This takes precedence over any local ‘place of safety’ arrangements⁵⁹. The draft College of Policing APP on mental health also takes a similar approach, and states that where a police officer makes a detention under section 136, they must also request an ambulance. There is also a National Ambulance Service section 136 protocol which should be taken into account⁶⁰.
- 4.52 This means that there should be no circumstances where a person suffering from Acute Behavioural Disturbance is taken to a police station, even if their behaviour is ‘difficult to manage’. The key is for police officers being sufficiently trained to be able to recognise a serious medical emergency.

Liaison and Diversion Schemes

- 4.53 Liaison and diversion schemes can play an important role in ensuring that vulnerable people do not go into custody in the first place, especially if the need for medical care far outweighs the significance of the alleged offence. Diverting vulnerable people with mental ill health away from police custody to mental healthcare facilities when the nature of the offence may not demand prosecution in the public interest could be an important way to ensure that people for whom an arrest would represent a ‘crisis’ might avoid the stress of detention that could trigger suicidal thoughts and actions. Clearly this would not be an option in situations where the crime is sufficiently serious to warrant immediate police questioning or remand in custody pending a court appearance but diversion should always be considered if there is a perceived risk of suicide and the public interest does not demand a custodial remand or prosecution, or when a detainee is granted bail.
- 4.54 The 2009 Bradley Report⁶¹ focused on liaison with mental health and other support services and diversion from the criminal justice system. In June 2014 a report by the Centre for Mental Health on behalf of the Bradley Commission, “*The Bradley Report 5 Years On*”⁶², found that there had been progress in “realising the Bradley Report vision” for liaison and diversion. The Government in response to the Report invested £50 million to support over 100 services nationally.

59 ACPO/NPIA 2010 Guidance on Responding to People with Mental Ill health or Learning Disabilities para 3.8.2

60 <http://www.crisiscareconcordat.org.uk/wp-content/uploads/2015/09/A1-National-Section-136-Protocol-complete-v2-FINAL-version-Reviewed-April-2015.pdf>

61 <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>

62 <https://www.centreformentalhealth.org.uk/the-bradley-report-five-years-on>

4.55 In February 2015 the Home Affairs Committee Inquiry on Policing and Mental health stated:

“Liaison and diversion (L&D) is a scheme that places mental health experts within police custody suites and courts, to identify early when someone who has been arrested has a mental illness, and refer them to support. This would include someone, of any age, who has one or more of the vulnerabilities associated with mental illness, drug and alcohol dependency, and learning disabilities. There are currently ten trials funded by the NHS, at a total cost of £25 million, with a further nine expected to be announced soon. NHS England plans for L&D services to be available in all police custody suites and all courts by April 2017.

“Similar to Street Triage, Liaison and Diversion services are intended to ensure that a person with mental health problems who does come into contact with the police and the courts receives appropriate treatment. The prevalence of people with mental illness within the criminal justice system is a scandal and any initiative that addresses this should be welcomed. However, its success will clearly rely on the availability of appropriate mental health services to which clients can be referred.”

4.56 Following a launch of ten pilots in April 2014, roll-out of a second wave of 12 further schemes commenced in April 2015. This extended Liaison and Diversion services to 50% of the population of England. On 13 July 2015 a further £12m of Department of Health funding was announced to support continued roll out of the schemes to 75% of the country by 2018. These schemes are hugely important as they can deal with varied issues such as mental health, learning disabilities and difficulties and substance misuse in a holistic and joined-up way. These schemes continue to be monitored.

Avoiding detention under section 136 Mental Health Act 1983

4.57 Triage schemes staffed jointly by officers and mental health nurses are being piloted in various parts of the country. Under these schemes psychiatric nurses work closely with police officers to determine if there are mental health needs in any given incident. This allows for the appropriate body to deal with a public incident, especially in situations where no crime has been committed and there is no obvious need for police intervention.

4.58 Such local initiatives around the country have the potential to greatly reduce the use of section 136. Evaluation of the initial nine pilots found that for the eight areas where data was available, there was a 12% average reduction in use of section 136 compared to an equivalent period in each area.⁶³ The HAC Inquiry on Policing and Mental Health called for the Government to commit to funding for when the pilots come to an end.

63 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/20206.htm#n78>

4.59 A further evaluation report of the nine initial street triage schemes was published in March 2016. The results of this evaluation are generally positive, and conclude that:

“All but two of the nine Street Triage schemes resulted in a reduction in the use of section 136 detentions, when compared with an equivalent timeframe from the previous year...Overall, the mean difference across the pilot schemes was 11.8%; when comparing the six sites where a reduction in s136 use was seen, the mean reduction was 21.5% (15.5% to 27.5%).”⁶⁴

Use of police officers to conduct restraint within mental health detention settings

4.60 There have been deaths that have followed the use of restraint by police officers called to attend NHS mental health settings and this is a key area of concern, as the following two cases illustrate:

“Olaseeni Lewis: Mr Lewis was 23 years old when he died following prolonged restraint at the Bethlem Royal Hospital in South London on 31 August 2010. He was a successful graduate with a degree in IT and plans for further postgraduate study. In August 2010 he was physically well and had no history of mental illness. But within 48 hours of beginning to exhibit uncharacteristically odd and agitated behaviour – and within 18 hours of being brought to hospital – he was all but dead, having collapsed in the course of prolonged restraint involving 11 police officers. He never regained consciousness, and he was eventually pronounced dead four days later, on 4 September 2010.”

“Kingsley Burrell: Police officers summoned to a Birmingham mental health hospital threatened to use tasers (sic) and used rear cuffs and leg restraints. Mr Burrell was restrained on a hospital trolley face down with a blanket placed over his head. Over a total period of restraint of two and a half hours he was also subjected to baton strikes and punches.”

4.61 In 2004, following the death of Roger Sylvester, a review by the Metropolitan Police Service (MPS) acknowledged that the use of police officers to restrain patients in mental health hospitals was a common practice. That review recommended that the NHS should train their staff in methods of restraint and minimise the need to employ police officers for this purpose. According to a response by the MPS to a Freedom of Information request from a member of the public in March 2016⁶⁵, this recommendation was still a live issue and being progressed through the Restraint Expert Reference Group chaired by Lord Carlile.

64 <http://www.crisiscareconcordat.org.uk/inspiration/ucl-street-triage-final-report-march-2016/>

65 http://www.met.police.uk/foi/pdfs/disclosure_2016/march_2016/2016020001396.pdf

4.62 INQUEST, in their response to the National College of Policing consultation on a new draft APP on mental health stated:

“We would suggest that to the extent that any police role is ever considered necessary in a health care setting, this should be kept to an absolute exception with clear guidance concerning the continued and overall management/responsibility of these situations by senior medical staff present. Language (contained in the draft) like patients presenting “management problems” or “a breach of the peace or other offence has occurred or is anticipated” raises serious concerns in terms of possibly wide interpretation and the potentially low threshold for police involvement. We believe an unambiguous and high threshold should be set in terms of any police involvement, capable of being clearly understood and properly judged by all staff.

“Given restraint has been a key feature of all police related deaths in health settings, we believe there should be a clear instruction that police should not be permitted to use face down restraint when called to any health setting. Considerable learning in the psychiatric sector has led to significant limits being placed on the use of restraint, understanding the dangers to this vulnerable group. The same standards of safety and welfare should be applied in any police intervention.

“To the extent that circumstances may arise where additional support is needed to help respond and manage a heightened situation, we believe this skill and resource should be developed internally by health care staff. The greater the number of incidents and circumstances said to justify the call for police attendance, the greater the risk of building an over reliance and expectation of police involvement by healthcare staff (particularly given increasing pressures on resources and staff). The increasing use of temporary and/or agency staff in psychiatric settings (generally holding less experience and lacking continuity of care) also raises further questions around the judgement of issues like how agitated behaviour or minor incidents of potential criminality should be judged.”

Recommendations:

- Commitment and responsibility at leadership level is needed across police forces to ensure prioritisation of the issue of mental health and to bring about sustained cultural, organisational and practical changes.
- Police recruitment and training should incorporate the different personal skills and experiences needed to fulfil duties relating to the needs of highly vulnerable groups, including empathy, communication skills and the ability to employ de-escalation techniques. This should be embedded in the police appraisal process with assessment made on the correct use of force and, in particular, where officers have been able to avoid the use of force.
- There should be consistent national police policy and guidance encompassing current learning and best operational practice, reflecting the need for a drastically improved policing approach to those in mental health need.
- National, comprehensive, quality assured mental health training consistent with the above is needed for all officers in front-line or custody roles. This should span all new recruits and regular refresher training. Training should be interactive and should involve mental health users to help break down fears and assumptions.
- There should be proper resourcing of national healthcare facilities to accommodate and respond to vulnerable people in urgent physical and/or mental health need coming into contact with the police.
- There should be clear procedures around the operation of section 136 from initial point of contact, including joint protocols between police, local health services and voluntary sector organisations. Health-based 'places of safety' should not be permitted to exclude those who are intoxicated or showing signs of agitated/aggressive/disturbed behaviour.
- The use of police vehicles for transporting people detained under section 136 should be stopped in all but the most exceptional of situations. These are health emergencies (particularly where force has been used) and an ambulance should be summoned for all section 136 detainees.
- The use of police stations as section 136 'places of safety' should be completely phased out. Guidance should not advocate the use of police custody on the grounds that a detainee's behaviour would be 'difficult to manage' in a healthcare setting.
- Successful local mental health policing pilots and initiatives, particularly street triage and liaison and diversion schemes should be funded on a sustainable basis for national roll out so that, as far as possible, those in mental health need are dealt with through medical and community based pathways not through police detention. Such schemes should be subject to regular review.

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- An unambiguous and high threshold should be set for police involvement in any health care setting. Clear guidance should identify medical primacy of role in any health based setting involving the police.

5. Ethnicity

5. Ethnicity

Introduction

- 5.1 The 1999 Macpherson Report⁶⁶ into the death of Stephen Lawrence was a watershed moment in the history of the police and race relations. Its author, Sir Iain MacPherson, included in the Report an extract of a submission by Dr Robin Oakley on the nature of the dynamics in operation in the policing of ethnic minority communities - a relationship which has been a fruitful source of tension and misunderstanding over many years,

“For the police service, however, there is an additional dimension which arises from the nature of the policing role. Police work, unlike most other professional activities, has the capacity to bring officers into contact with a skewed cross-section of society, with the well-recognised potential for producing negative stereotypes of particular groups. Such stereotypes become the common currency of the police occupational culture. If the predominantly white staff of the police organisation have their experience of visible minorities largely restricted to interactions with such groups, then negative racial stereotypes will tend to develop accordingly.”⁶⁷

- 5.2 In response to its unequivocal finding that the Metropolitan Police Service was institutionally racist, Sir Iain Macpherson made various recommendations about police training. These included:

“That training of Family Liaison Officers must include training in racism awareness and cultural diversity, so that families are treated appropriately, professionally, with respect and according to their needs.

“That all police officers, including CID and civilian staff, should be trained in racism awareness and valuing cultural diversity.”

- 5.3 The House of Commons Home Affairs Committee, in its 2009 report, ‘Macpherson Report—Ten Years On’,⁶⁸ stated that most of the recommendations had been implemented and that there was ‘continuous education and training of police officers’. The form and efficacy of this training will be discussed later in this chapter.

66 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf

67 Paragraph 6.1

68 <https://www.publications.parliament.uk/pa/cm200809/cmselect/cmhaff/427/427.pdf>

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- 5.4 The Government has acknowledged that there is ‘significant overrepresentation of Black, Asian and minority ethnic (BAME) individuals in the criminal justice system’ and consequently, in January 2016, announced that David Lammy MP would lead a review to investigate evidence of possible bias against Black defendants and other ethnic minorities⁶⁹. The interim findings published in November 2016 found disproportionality within the legal system and that “arrest rates are generally higher for the BAME population in comparison to the White population”.⁷⁰
- 5.5 Casework from groups providing support to families has highlighted that a disproportionate number of people who have died following the use of force were from BAME communities. This is reflected in official IPCC statistics, although since 2008/09 the IPCC has not provided a breakdown of ethnicity as against restraint related deaths. Causes of death at post mortem relating to use of restraint on people from White and BAME backgrounds between 2004/05 and 2014/15 is similar at 10% and 11% respectively⁷¹. However, this only denotes whether the use of restraint was an explicit cause of death, and not whether restraint was used during the arrest or detention of the person. The issue of force and restraint is discussed in more detail in Chapter 2.

“Deaths of people from BAME communities, in particular young Black men, resonate with the Black community’s experience of systemic racism.”

- 5.6 Deaths of people from BAME communities, in particular young Black men, resonate with the Black community’s experience of systemic racism, and reflect wider concerns about discriminatory over-policing, stop and search, and criminalisation. The Government report *Police powers and procedures, England and Wales, year ending 31 March 2016* was published on 27 October 2016 and stated that while searches had fallen across all groups (searches on White individuals by 38%, searches on Black and Minority Ethnic individuals by 13%) compared with the previous year, nevertheless:

“Those from BME groups were 3 times as likely to be stopped and searched as those who are White. In particular, those who are Black (or Black British) were over 6 times

69 <https://www.gov.uk/government/news/review-of-racial-bias-and-bame-representation-in-criminal-justice-system-announced>

70 <https://www.gov.uk/government/news/lammy-review-emerging-findings-published>

71 Deaths in police custody: A review of the international evidence

more likely to be stopped. In both cases these figures were higher than the previous year, and reflect the fact that although stops of all ethnicities have fallen, stops of White individuals have fallen by more than stops of BME individuals.”

- 5.7 Institutional racism identified in the Macpherson report still appears to be an issue within the police service. This was alluded to by Theresa May on becoming Prime Minister when she said:

“If you’re Black, you’re treated more harshly by the criminal justice system than if you’re white.”⁷²

- 5.8 Inevitably any death involving a BAME victim who died following the use of force has the capacity to provoke community disquiet leading to a lack of public confidence and trust in the justice system. This can be exacerbated if people are not seen to be held to account, or if the misconduct process is opaque. There is a wider social and political context in which such deaths have occurred, often involving misinformation in the media about the deceased and their family, and the fact that despite Inquest verdicts of unlawful or excessive force, the authorities rarely appear to be held to account.

- 5.9 The restraint-related deaths following police contact of Roger Sylvester and Sean Rigg highlight this issue. Although the deaths occurred nine years apart, there were many similarities (for example, the use of the prone restraint position) to the extent that it may be questioned what, if any, lessons were learned in the interim. As INQUEST observed:

“Both involve inappropriate use of force on two vulnerable Black men, which is illustrative of how little has changed. Both cases saw police reliance on racial stereotyping of Black men as having ‘exceptional strength’. Both deaths took place in communities that had seen a pattern of police related deaths involving the Metropolitan Police Service.”

Race and the investigative process

- 5.10 Ethnicity formed a part of the terms of reference into the death of Sean Rigg and yet despite this, the initial IPCC report did not address the issue. This apparent omission was later identified in the Casale Review⁷³:

“One of the terms of reference of the IPCC investigation was “To establish whether any acts or omissions of any police officers were motivated by the ethnicity of Sean Rigg.” Therefore, race was an issue that needed to be considered by the IPCC, whether or not it then found there to be any concerns to be raised regarding racial discrimination. The IPCC’s own internal review emphasised that it had found no evidence that the interviews explored whether any acts or omissions of any police officers were motivated by the ethnicity of Mr Rigg.”

72 <https://www.gov.uk/government/speeches/statement-from-the-new-prime-minister-theresa-may>

73 Casale report, p71

5.11 The Casale review further concluded that:

“The IPCC should not be afraid to identify the primary, contentious features in a case e.g. mental health, restraint and race. This is not to prejudge the investigation or with the purpose of ruling those issues in or out but to make clear the IPCC is aware of and has identified the primary concerns and issues that need to be examined. To put on public record that the IPCC recognises the important questions and issues to explore and is there to conduct a robust investigation will go some way to satisfying the public interest and concern about these deaths.”

5.12 A number of people who gave evidence to this review considered that race and ethnicity should automatically be considered as a factor in any investigation where these characteristics are present, unless proven otherwise. The concern that the issue of race is not always considered in investigations is a longstanding issue that was raised in the Macpherson report. Sir Iain queried whether officers failed *“fully to accept “racism and race relations” as a central feature of the investigation?”* (paragraph 6.36). Investigators need to start with an open mind and go where the evidence takes them, but there is a need to think ahead of the evidence in order to give full consideration to the potential for discriminatory treatment and practices from the outset in every such investigation.

5.13 INQUEST suggested in its submission to this review that historically the issue of race and racism is generally not referred to by the IPCC or included in the terms of reference of its reports. However, the IPCC has made efforts in this regard in response to concerns raised. In its March 2015 report *Update on the action plan from the Review of the IPCC’s work in investigating deaths* it is stated that:

“Guidance in our operations manual about drafting terms of reference has been updated to make sure that consideration is always given to whether there are any possible discrimination issues which require attention as part of the investigation... We have continued to seek the involvement of families in developing the terms of reference for the investigation to make sure that they are as engaged as they can be, or want to be, in the investigative process.”

5.14 In September 2015 the IPCC published *“IPCC guidelines for handling allegations of discrimination”*⁷⁴ in an attempt to tackle some of the issues raised in this chapter. By way of example the guidance states:

“To address the allegation of race discrimination the investigating officer should ask themselves: What types of assumptions, prejudices or bias might lead to a Black man with mental health issues being treated differently due to his race and resulting in the use of excessive force? Would a white man with mental health issues acting in a similar way be treated by these officers in the same way?”

74 https://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/Guidelines_for_handling_allegations_of_discrimination.pdf

“Were assumptions made that Mr A’s behaviour was a result of drug taking, aggression or criminality rather than symptoms of mental health crisis and a reflection of vulnerability? Would similar assumptions have been made if he was a white man?”

“Were assumptions made that Mr A posed a greater threat/risk because he was Black? Were assumptions made that he was particularly strong or more likely to resist or to be violent? Would the same assumptions and risk assessment have been made if he was white?”

- 5.15 The passage from the Guidelines illustrates that the IPCC is aware of many of the issues facing potentially vulnerable BAME people in police custody, especially where mental illness may be a factor. Together with guidelines on writing Terms of Reference, the Guidelines are positive developments and the IPCC should continue to make every effort to give all due consideration to including the investigation of race and ethnicity as a factor.
- 5.16 It is also felt by some that the IPCC look at cases in isolation without reference to the wider social and political context. They believe that racial stereotyping needs to be investigated within the context of a wider picture of related deaths and non-fatal incidents where race may have been a factor. It is difficult to be able to prove that racism was a factor in deaths in police custody unless sufficient evidence exists and racism can be inferred from the specific facts and circumstances of that case or from a series of such cases of a similar nature arising from the conduct of the suspect officer.
- 5.17 Racial stereotyping may or may not be a significant contributory factor in some deaths in custody. However, unless investigatory bodies operate transparently and are seen to give all due consideration to the possibility that stereotyping may have occurred or that discrimination took place in any given case, families and communities will continue to feel that the system is stacked against them.

Stereotypical assumptions

- 5.18 The stereotyping of young Black men as ‘dangerous, violent and volatile’ is a longstanding trope that is ingrained in the minds of many in our society. People with mental health needs also face the stereotype of the mentally ill as ‘mad, bad and dangerous’. There is therefore a particular concern with what INQUEST describes as ‘double discrimination’ experienced by Black people with mental health issues.

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- 5.19 INQUEST reported to this review that its casework has revealed a use of force and restraint that is disproportionate to the risks posed ‘especially where there is one detainee and a large number of officers’. Equating mental illness symptoms like agitation and disorientation with a propensity for violence can mean that the perceived risk posed by the detainee may obscure people to their vulnerability. It is not uncommon to hear comments from police officers about a young Black man having ‘superhuman strength’ or being ‘impervious to pain’ and, often wholly inaccurately, as the ‘biggest man I have ever encountered’. Such perceptions increase the likelihood of force and restraint being used against an individual who may be unwell. The detainee is effectively dehumanised. In such circumstances the police officers may also use force and restraint in order to gain compliance to the exclusion of any focus on the wellbeing of the detainee which can ultimately lead to a medical crisis or death. This issue is explored further in Chapter 2 (Restraint).
- 5.20 Dr Casale’s review following the death of Sean Rigg explains how an officer described Sean Rigg’s behaviour as possibly related to mental health, but also ‘other reasons’ “*especially with people you come across in Brixton*”. Dr Casale stated that:
- “This response raises a number of concerns. Which other reasons, apart from mental health, are meant? Is bizarre behaviour, such as Mr Rigg was described as exhibiting, normal behaviour for “people you come across in Brixton”? What are the other reasons that might explain Mr Rigg’s “unusual” behaviour? It may be that PC Glasson had some reason other than race in mind, but the question was never asked. This needed to be pursued by the IPCC. The lack of reference to race throughout is not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately.”*
- 5.21 There is also concern that assumptions made about someone may lead to the denial of medical care. Experienced officers may believe they know when someone is faking an illness, but such assumptions can prove fatal. The death of Christopher Alder is a case in point. Officers laughed and joked whilst he lay dying on the floor of the custody suite. They reported that he was faking. He died after being left unconscious face down on the floor for 11 minutes.
- “His trousers were around his knees, he had been doubly incontinent and blood formed a pool around his mouth. CCTV footage showed that apart from removing the handcuffs when he was initially brought into the police station the four police officers present did not touch or check him in the 11 minutes he lay dying on the floor despite his condition. Rattles of his breath were also clearly heard on the video – INQUEST written evidence”*
- 5.22 The IPCC Review into his death was clear that racist attitudes contributed to Mr Alder’s death. The then Chair of the IPCC Nick Hardwick commented:
- “...I do believe the fact he was Black stacked the odds more heavily against him...the officers’ neglect undoubtedly did deny him the chance of life.”*

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- 5.23 The IPCC conclusion that the officers' failure to give medical care to Mr Alder meant that he "*did not matter enough for them to do all they could to save him*" is a damning indictment of the conduct of the officers involved, who, in the opinion of Nick Hardwick were "*guilty of the most serious neglect of duty*".
- 5.24 The jury at Christopher Alder's inquest in 2000 returned a unanimous verdict of unlawful killing by gross negligence manslaughter. A prosecution for manslaughter and misconduct in public office resulted in an acquittal after the Judge directed that the police officers could not safely be convicted on the evidence on either count that they faced.
- 5.25 Guidance issued by the Association of Chief Police Officers (now the National Police Chief's Council) and the National Policing Improvement Agency in 2010 accepted that racial stereotyping needs to be addressed. The guidance states:
- "To avoid misperceptions (for example, that members of BME groups are more likely to be dangerous) and where there is time, the police should attempt to assess the risk against a set of constant parameters."*⁷⁵
- "In considering how to manage an individual with evident mental ill health, the police need to challenge the stereotype that mental ill health equals dangerousness and that, because of this, restraint techniques are more likely to be required."*⁷⁶
- 5.26 The May 2013 report by the Independent Commission on Mental Health and Policing stated:
- "In most cases, there were failures in systems, misjudgements or errors by individuals, resource limitations, poor co-ordination with other services or discriminatory attitudes towards people with mental illness that led eventually to these deaths."*
- 5.27 While accepting that progress has been made since the Macpherson Report, it is clear that police training needs to include an understanding of institutional racism and how it relates to deaths of people from BAME communities in custody, as well as an understanding of human rights and diversity. The profound impact on community relations should also be recognised.

Statistics on ethnicity

- 5.28 Figures taken from the IPCC's annual statistics on deaths during or following police contact show that in recent years the majority of people who have died in or following police custody were White. Over the last five years 86% were White and 14% were from other ethnic backgrounds. Over the last 11 years 88% were White and 12% were from other ethnic backgrounds.

75 ACPO/NIA Guidance, 2010, para 3.7.2

76 ACPO/NIA Guidance, 2010, para 3.8

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- 5.29 The accompanying Home Office research report *Deaths in police custody: A review of the international evidence* found that the proportion of Black people dying in police custody was lower than the proportion arrested for notifiable offences (6% and 8% respectively). However, a disproportionate number of people from BAME communities (and those with mental health concerns) have died following the use of force. The IPCC deaths in custody report for deaths between 1989/99 to 2008/09 stated:
- “Previous research has raised particular concern about deaths involving ethnic minority men and police restraint (Leigh et al, 1998; PCA, 2002b; OHRN, 2009). In this study, of the 87 restrained at any point, 67% (58) were White, 16% were Black, 7% were of Mixed ethnicity, and 6% were Asian. Ethnicity was not stated in 5% of cases. Comparing this with the details presented shows that Black people, and those of Mixed ethnicity, therefore formed a greater proportion of those restrained than they did of the entire sample, while the opposite was true of White people. When the BME groups were combined for analysis, people from BME groups were significantly more likely to be restrained than White people.”*
- 5.30 Since the 1989/99 to 2008/09 report the IPCC has not provided a breakdown of restraint related deaths by ethnicity. As a result, restraint related deaths are no longer identified separately but fall within the ‘deaths in or following police custody’ category. This category includes deaths which do not involve the use of force. Furthermore, deaths following the use of force that take place outside of police detention (such as police restraint in mental health settings) are placed in the “other deaths” category.
- 5.31 The March 2016 IPCC report on Use of Force contains an analysis of ethnicity for the sample group used for the report, predominantly non-fatal cases, but no ethnic breakdown for deaths following the use of force. The IPCC’s own sample of data involving complaints made following the use of force showed that there were significant gaps in the police service’s recording of the ethnicity of those on whom force was used. Ethnicity was not recorded in a quarter of complaints about the use of force.
- 5.32 When the IPCC looked at cases of use of force that were independently investigated or managed by the IPCC, where ethnicity was known, almost three-quarters of those on whom force was used were white (71%, 147 people), and 60 (29%) were from other ethnic backgrounds.
- 5.33 The IPCC did not find any significant differences in the type and frequency of force between the two groups, but did find that incidents involving people from BAME communities were much more likely to take place in a public setting (73%) than a person’s home (15%) compared to the White sample (58% and 23% respectively).

5.34 As the IPCC stated in evidence given to this review:

“We are conscious that the figures do not necessarily reveal the multiple issues surrounding ethnicity and death or serious injury. Any death involving contact with the police has the potential to impact on trust and confidence in the police more broadly. This is particularly true in BME communities, where a number of high profile deaths have caused significant concern, and where we know that there is in general less confidence in the police complaints system.”

5.35 The reason for the lack of confidence in the police complaints system can be attributed to the wider social and political context of such deaths, discussed earlier in this chapter.

5.36 In relation to all deaths (not just those involving restraint) the IPCC report for 1998/99 to 2008/09 sets Black deaths at 7% and also notifiable arrests at 7%. However, notifiable arrests are not on their own a relevant benchmark because they consist of the more serious offences and do not include the most common reasons for detention of those who die in police custody, for example section 136 Mental Health Act 1983 detainees, or minor public order offences which are not notifiable offences such as public disorder or drink driving. Nearly half of deaths in police custody followed detention for a reason other than arrest for a notifiable offence. While estimates vary, notifiable offences may account for two-thirds of all detentions in police custody.⁷⁷

5.37 It should also be noted that police forces in England and Wales do not currently include Gypsies and Irish Travellers communities in their ethnic monitoring systems, despite both these groups being classified as ethnic minorities in the ONS 2011 National Census.

5.38 Without such monitoring it is not possible to have a complete understanding of how traveller communities experience police custody. In written evidence to this review the Traveller Movement stated their concern that people from Gypsy, Romany and Traveller communities are overrepresented in the criminal justice system, and routinely face ‘overzealous policing’. They stated:

“Overzealous policing and brutality are common occurrences on Traveller site raids and evictions. Men in particular are usually arrested during these events and routinely report they have been slapped about while in custody and threatened. Few if ever take any action against the police because of fear of further intimidation and evictions. Many believe “its part and parcel of being from the wrong ethnic group”.”

5.39 Such concerns can only be properly evaluated and addressed if there is mandatory ethnic monitoring of Gypsy Roma and Traveller communities in England and Wales.

Accountability

- 5.40 The Inquest system in England and Wales is an important mechanism for learning from institutional failings. Executed properly it should allow the facts to emerge and thereby increase community confidence in the system, and allow forces to learn lessons from what went wrong. The very significant delays in various investigations that consequently delay Inquests can only damage the prospect of learning these lessons in a timely fashion. This is discussed in more detail in Chapter 16 (Coronial system).
- 5.41 However, it is not just Inquest delays that can lead to a loss of trust in the system. For families of those who die in police custody, there is a lack of belief in the effectiveness of the whole system, from the police, Independent Police Complaints Commission, Crown Prosecution Service and Inquests to deal effectively with these cases. There can only be a rebuilding of confidence if people who fail those in their custody are held to account, and if actions are taken to prevent future incidents occurring.
- 5.42 The disproportionately high number of deaths of Black men in restraint related deaths, often in contentious circumstances, is a serious issue because it connects so vividly with the perception many in the BAME community have of the police service. It reflects wider community concerns about discriminatory policing. Where there is evidence of racist or discriminatory treatment or other criminality or misconduct, police officers must be held to account through the legal system. Failure to do so undermines community confidence in the police and is damaging to police and community relations. Community confidence and trust in the police has been undermined in the BAME community and can only be rebuilt with a real effort to learn from institutional mistakes.

“Where there is evidence of racist or discriminatory treatment or other criminality or misconduct, police officers must be held to account through the legal system.”

Recommendations:

- The IPCC should ensure that race and discrimination issues are considered as an integral part of its work. This should be monitored and fed into internal learning and the IPCC's 'watchdog' role.
- IPCC investigators should consider if discriminatory attitudes have played a part in restraint-related deaths in all cases where restraint, ethnicity and mental health play a part (in line with the IPCC discrimination guidelines). A systematic approach should be adopted across the organisation.
- The IPCC should address discrimination issues robustly within misconduct recommendations, including where discrimination is not overt but can be inferred from the evidence in that specific case or from similar cases involving the same officer.
- National policing bodies and police forces should implement mandatory training and refresher training on the nature of discrimination, including on race issues, which aims to confront discriminatory assumptions and stereotypes. Policing bodies should consult with bereaved families on how such training can break down barriers and promote change. Training should take the form of a two-way dialogue allowing officers to hear the experiences of people from BAME backgrounds and include participation of bereaved families. Police training should include an understanding of institutional racism, the Macpherson report, the social context of Black deaths in custody and the impact they have had on public confidence.
- The IPCC should monitor the correlation between ethnicity and restraint-related deaths, including in healthcare settings where the police were involved. Statistics should be published breaking down restraint related deaths by ethnicity.
- The national programme for police data collection on the use of force must include ethnicity and mental health (as well as other factors relevant to discrimination) in all force data so as to provide a standardised national picture.
- National data collection on the use of force should be analysed by the Home Office to draw out patterns and devise national strategies to address discrimination issues. The outcome of data collection and analysis should be made public.
- The IPCC should monitor ethnicity and deaths in custody against ethnicity and arrests by reference to all arrests, including non-notifiable offences.
- There should be mandatory ethnic monitoring of Gypsy Roma and Traveller communities in England and Wales by police forces in their ethnic monitoring systems.

6. Self-inflicted deaths

6. Self-inflicted deaths

Introduction

- 6.1 Often, people who find themselves in police custody are highly vulnerable due to pre-existing mental health difficulties or because of the circumstances of the arrest. People arrested for crimes relating to sexual offences or domestic violence, for example, may fall into this category due to the stigma of arrest for such offences. The number of apparently self-inflicted deaths by a detainee within two days of their release from police contact is high. According to IPCC statistics there were 60 such deaths recorded in 2015/16.
- 6.2 According to the Home Office Research Report 'Deaths in Police Custody: A review of the international evidence' between 2004/05 and 2015/16, 91 per cent (582 of 638) of deaths from apparent suicide following police custody were male. "Over the same period a slightly lower proportion of those arrested for notifiable offences were also male (84%) (Home Office, 2016a). This compares with 76 per cent of suicides that involved males amongst the general population in England and Wales as registered by the Office for National Statistics (ONS) between calendar years 2004 and 2014 (inclusive) (ONS, 2016a)".
- 6.3 It should be recognised however that there has been real progress made in reducing self-inflicted deaths within police stations. The accompanying report, Deaths in police custody: A review of the international evidence, builds on analysis in the IPCC Deaths in Custody Report in looking at causes of death. For the years 1998/99 to 2015/16 there were 45 self-inflicted deaths in police custody, of which 34 were hangings. The IPCC reported a reduction from 14 hangings in 1998/99 to generally only 1-3 a year in the following years until 2008/09. Since then, there has been one self-inflicted death in a police cell, in 2014/15, and, sadly, another report of such a death in December 2016.

“There has been real progress made in reducing self-inflicted deaths within police stations.”

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- 6.4 This reduction has been brought about by a determined effort by police forces to tackle the issue. Efforts to remove ligature points, ligatures and to ensure constant observation have all had a positive effect. A similar awareness needs to be raised for potentially vulnerable people at the point of arrest, continuing throughout the period of detention, and particularly at the point of release.
- 6.5 Apparent suicides following release from police custody are reported by the police to the IPCC if they happen within two days of a detainee being released from police custody. They are also reported if the time spent in custody may have been relevant to the subsequent death, and the death has been referred to the IPCC. According to the IPCC, the police may not always be told of an apparent suicide, as this association may not always be clear. There may therefore be additional deaths that go unreported. However, one reason for the higher level of suicides within 48 hours of release over the last few years may be the more effective identification and reporting of such deaths on the part of the police.
- 6.6 Official IPCC statistics show that the majority of people who take their lives following police custody were reported to have had mental health concerns. In 2015/16, for example, 33 of the 60 who took their own lives had mental health concerns:
- “More than half of the individuals (33) had known mental health concerns. Of these, one had been detained under Section 136 of the Mental Health Act 1983. Other mental health concerns included depression, schizophrenia, post-traumatic stress disorder, or previous thoughts or incidents of suicide attempts or self-harm.”⁷⁸*
- 6.7 As the Inquest Lawyers Group observed in written evidence to this review:
- “There are serious questions arising regarding why these individuals were detained in police cells rather than transferred to an appropriate healthcare setting; what risk assessments were conducted prior to their release; and what arrangements, if any, were made for “aftercare.” Robust risk assessment on release and onward referrals to specialist services are vital to protect individuals in the period post-release from custody.”*
- 6.8 Police custody should therefore be considered as an opportunity to identify mental health needs, look out for signs of potentially suicidal individuals, and if necessary divert to healthcare facilities. As has already been observed, very successful steps have already been taken by the police to reduce suicides within custody. The challenge now should be to take similar, concerted action to reduce post-release deaths.
- 6.9 The Equality and Human Rights Commission’s 2016 report *‘Non-natural deaths following prison and police custody’* found a lack of accountability and inadequate record-keeping by responsible agencies; that the wellbeing of people released from prison or police custody is not always monitored and managed properly after detention, even when it is known that they have a mental health condition which could put them at risk of suicide.

78 Deaths during or following police contact, IPCC, 2015/16

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- 6.10 INQUEST has experience of working with families of some highly vulnerable detainees who have died within a short time of release. In these cases the families are understandably anxious to know whether any opportunities were missed in police custody that could have led to a different outcome for their loved one. INQUEST has referred to two cases, below, which highlight some of these issues.

*“**Mr C:** Mr C was arrested following domestic abuse allegations by his girlfriend that he strongly denied and he was not charged. She provided his psychiatric medication to the police. Mr C had markers on police systems for self-harm and suicide. Immediately after being placed in a cell he tried to tie clothing round his neck, was stopped by officers and placed on constant observation. Although he became calmer during his period of detention he remained upset. He was released on bail without any family member being contacted, his family being unaware of the arrest. There was no attempt by the police to seek any external support for him upon release. The next day Mr C was found hanging in his house. The police investigation concluded that a more thorough pre-release risk assessment should have been carried out. Furthermore this risk assessment was not completed until some time after the release.”*

*“**Kesia Leatherbarrow:** 17 year old Kesia was arrested on suspicion of criminal damage and possession of cannabis. She was extremely distressed in police custody and told police officers she was going to jump off a bridge once released. Whilst this was noted on the custody record, a full risk assessment was not completed at any time during her detention in the police station. Despite her age, known mental health problems and vulnerabilities the police, the youth offending team and her solicitor allowed her to leave court alone after being released on bail without making any attempt to contact a family member. She was found hanging in a garden after being released by the court.”*

- 6.11 IPCC figures for apparent suicide within two days of release show the numbers of such deaths to be high: 65 in 2012/13, 70 in 2013/14, 70 in 2014/15 and 60 in 2015/16. A large proportion involves those arrested for sexual offences (30% between 2004/05 and 2014/15).⁷⁹ As INQUEST observes, stigmatising arrests are ‘clearly a risk factor’ and ‘an arrest may represent a serious crisis added to the fact that many of those detained have on-going mental health vulnerabilities’. However, not all those who take their life due to stigmatising arrests have a documented history of mental ill health issues and will therefore score low on any standard risk assessments. Pre-release risk assessments need to take this into account.

Pre-release Risk Assessment

6.12 Well formulated and consistently applied pre-release risk assessments are crucial for identifying potentially suicidal people before release. However, there is no single risk assessment used by all Forces. A failure to properly assess the needs of a detainee can lead to potentially preventable deaths.

6.13 In 2008, Lucy Smith was detained under section 136 of the Mental Health Act (1983) in Brighton, arriving drunk and apparently suicidal. She was found hanged at her home the day after her release. The jury concluded in this case that she hanged herself, while under the influence of alcohol and while suffering severe emotional turmoil. In a Rule 43 (prevention of future death) report following the inquest in 2009 the Coroner stated that:

“The release system is flawed. There is no place for a written pre-release risk assessment, nor is it good enough to say that Lucy “would have been given” this assessment, that her messages “would have been passed” to her, that she “would have been given” a bus pass, and that she “would have been given” a leaflet outlining her SECTION 136 detention. All these matters should be properly recorded.

“Furthermore Brighton Custody Centre is on the edge of the City, furthest away from Portslade where she lived and Lucy, and no doubt many others like her, had no idea how to get from Brighton Custody Centre to where they needed to be.

“Her release, I am afraid, smacks of just tipping her out to get rid of her.”

6.14 The February 2015 Home Affairs Committee Inquiry on Policing and Mental Health also made similar observations:

“81. Custody staff are responsible for carrying out a pre-release risk assessment of those who pass through their custody suite, assess if the person is vulnerable and if there is a credible risk that on release they may commit suicide. The custody officer needs to be trained to identify signs that would represent a risk of suicide and to be able to call upon healthcare staff in the custody suite who can provide expertise when necessary, and refer them to the appropriate support.

*“82. **The recent increase in suicides following custody is highly alarming. The police must make sure that those who have been identified as vulnerable in custody are notified to medical staff. There must be a formal method by which this is done and it must be followed. This will require additional training for custody staff but it also requires improvements in access to mental health nurses and doctors in the custody environment.**” (Emphasis in original text)*

6.15 The College of Policing Authorised Professional Practice (APP) on Detention and Custody states that:

“The custody officer should complete a pre-release risk assessment. They should not leave this until the point of release. Instead, it should be an ongoing process throughout detention and be concluded at the point of release. Custody officers

should refer to all existing risk assessment information for the detainee. They should also personally speak to all detainees prior to release. They then need to decide what action, if any, is appropriate to support vulnerable detainees upon release.”⁸⁰

6.16 The College of Policing should review this APP to look at what additional steps might usefully be taken, for example, contacting relatives, carers or friends (with the detainee’s consent) to meet the detainee upon release, or the possible use of diversion schemes. Being released into the care, or simply company, of another human being could make a difference. As one family stated in oral evidence to this review:

“There was a lack of any assessment. (The relative) was vulnerable and they knew he was a self-harm risk and they knew he was going through bankruptcy. They had a duty of care, but just let him go. The mental health assessment at the end was just a tick list.”

6.17 There are some examples of good practices already employed by police forces. The Metropolitan Police Service has a scheme whereby, with the detainee’s consent, they pass the phone number of the detainee to the Samaritans who will contact them post release. It is voluntary and confidential, and the Samaritans do not contact the police afterwards.

6.18 It should be acknowledged that pre-release risk assessments need to be considered and addressed earlier in the detention process to provide more opportunity to mitigate any risks upon release. It is often the case that the pre-release risk assessment is only addressed at the point of release, by which time opportunities may be lost. The APP makes clear that risk-assessment should be a continual process.

6.19 The HMIC Expectations for Police Custody inspection state that pre-release risk management planning for detainees should be conducted to ensure they are released safely. It sets out the following indicators of good practice:

- *“Good quality pre-release risk assessments are completed with the detainee: they are documented and identify any risks and vulnerability throughout their period of detention. Action is taken to reduce any risks and welfare concerns prior to release.*
- *“Appropriate relevant information about risk, vulnerability or safeguarding is communicated to relevant agencies and support organisations.*
- *“Particular attention is given to safely managing the release of vulnerable detainees.*
- *“There is up-to-date information, including contact details for support organisations, and this is provided to detainees in a format and language they can easily understand.*
- *“Person Escort Records are completed with all relevant detail, especially any issues relating to risk or self-harm.”⁸¹*

80 <http://www.app.college.police.uk/app-content/detention-and-custody-2/risk-assessment/#release-from-custody>

81 <https://www.justiceinspectorates.gov.uk/hmic/publications/expectations-police-custody-criteria/>

6.20 These expectations and the inspection process should form a key part in ensuring the safety of detainees at the point of release. There is evidence however from inquest findings that these checks and procedures are not adhered to consistently.

6.21 It should be recognised however that the police operate under highly volatile and sometimes stressful conditions. Custody Sergeants in particular have a huge responsibility. As the Police Federation stated in evidence to this review:

“They are charged with looking after some of the most vulnerable individuals within our communities. Detained persons are often violent, drunk, under the influence of drugs or a combination of all three; many have complex health and social needs and other vulnerabilities.”

6.22 This does not excuse any failure to adhere to checks and procedures, but it should never be forgotten that police officers are human, and mistakes will occur. The Police Federation itself acknowledges that, ‘improvements need to be made in training and developing officers and staff in effective risk assessment and decision making’, and further state that:

“The concept of pre-release risk assessment needs to be considered and addressed earlier in the detention time to provide more opportunity to mitigate any risks upon release. Too often pre-release risk assessment is only addressed at the point of release, by which time such opportunities may be lost.”

Medical advice at point of release

6.23 Medical advice for those who present a suicide risk can identify the appropriate avenues for support within the NHS system. For example, a joint medical and police risk assessment was adopted by Greater Manchester Police in the wake of the death of Kesia Leatherbarrow. The Coroner’s prevention of future death report stated that:

“Whilst this has been a significant commitment from Greater Manchester Police and has required the funding for an additional Doctor, the Court heard evidence that so far this risk assessment has been conducted on over 144 people leaving custody.

“This is clearly capturing a large number of people who are displaying signs of similar behaviour or thoughts as Kesia did whilst in custody and the Court heard that a joint medical and police risk assessment on their exit from custody is essential in trying to ensure appropriate support when they leave the police station.”

6.24 A joint medical and police risk assessment should be conducted using NHS resources. The provision of NHS services in the police custody setting is discussed in Chapter 12.

Other agencies

6.25 In written evidence to this review, the Police Federation made the observation that it is not just the police service that has a role to play in ensuring that detainees are safely released. There is a need for police forces to form closer ties with the NHS, mental health services, social services, housing organisations and others, to ensure that vulnerable detainees can be signposted or diverted to appropriate sources of help. The Police Federation also stated:

“Partner agencies need to take responsibility for the provision of support services around the clock. The police service provides 24 hour custody services and operations, however too often the services required to support the most vulnerable are only available during office hours.”

6.26 This is a holistic issue, and the onus on ensuring the safe release of detainees does not fall solely on the police. The availability of alternative facilities, proper funding of effective diversion schemes, and inter-agency communications all have a part to play.

6.27 The police and other agencies should also give similar consideration to the health and wellbeing of witnesses and victims who may also show suicidal thoughts or have significant mental health issues requiring urgent support.

Recommendations:

- The College of Policing APP on detention and custody and force training should include guidelines for pre-release risk assessment setting out specific practical steps that should be taken to provide support and protection for those at risk of self-harm on release (for example contacting family/carers before release with the detainee's consent, or referrals to community support groups).
- Custody inspections should continue to focus on the use of liaison and diversion schemes, pre-release risk assessment, and actions taken on release, as part of the inspection regimes of police forces.
- Police forces should include medical input in the risk assessment process at the point of release, provided by the NHS (assuming medical services within police stations are brought within NHS commissioning). (see Chapter 12).

7. Children and Young People

7. Children and Young People

Introduction

7.1 Children and young people who come into contact with the police are often among the most vulnerable in society. The police must make protecting the safety and welfare of children and young people in their care a ‘primary consideration’. The UN Convention on the Rights of the Child⁸² clearly sets out that criminal justice services must consider and prioritise the best interests of the child. The Convention defines a child as ‘every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier.’ Article 40 of the Convention states:

“A child accused or guilty of breaking the law must be treated with dignity and respect. They have the right to legal assistance and a fair trial that takes account of their age. Governments must set a minimum age for children to be tried in a criminal court and manage a justice system that enables children who have been in conflict with the law to reintegrate into society.”

7.2 The Youth Justice Board in evidence to this review stated that:

“Children and young people should be kept out of police custody as much as possible and they should not be detained in police custody for any longer than absolutely necessary and if refused bail should be moved to appropriate Local Authority accommodation as soon as possible. In circumstances where children and young people are held in police custody for any duration their safety and welfare should be considered paramount.”

7.3 Police forces across England and Wales have worked hard with partner agencies to reduce the numbers of children and young people arrested and brought into or kept in police custody. In Surrey, for example, the police have worked with agencies and NGOs to divert vulnerable people from custody and a scheme to specifically divert young people has seen numbers in custody reduce significantly⁸³.

7.4 There is a welcome downward trend in child arrests. According to Home Office statistics the number of 10 to 17 year olds arrested in England and Wales has decreased by two thirds since 2009/10 (88,577 in 2015/16 compared with 241,459 in 2009/10, a 63% reduction).⁸⁴ Indeed, arrests for 10 to 17 year olds have decreased more rapidly than arrests overall over this time (comprising 10% in 2015/16, a fall from 17% of arrests in 2009/10).

82 http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_PRESS200910web.pdf

83 <http://www.surrey.police.uk/news/police-and-surrey-county-council-praised-for-keeping-children-in-care-out-of-custody-by-independent-review/>

84 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561979/arrests-open-data-tables-ppp.ods

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- 7.5 Changes to PACE Code C have given 17 years olds the support of appropriate adults and required police to ensure parents are notified of their detention. Changes to legislation made via the Criminal Justice and Courts Act 2015 (and due in the Policing and Crime Bill) will bring the legal rights of 17 year olds fully in line with 16 year olds.
- 7.6 However, there is more work to do. Children and young people should be held in police custody only as a last resort, and where charged and refused bail they should be moved to appropriate local authority accommodation as swiftly as possible.

“Children and young people should be held in police custody only as a last resort.”

Post-release deaths

- 7.7 Unlike other forms of custody, for example, mental health detention, IPCC figures show there have been no deaths of children in police detention in more than 11 years. Analysis in the accompanying report *Deaths in police custody: A review of the international evidence* shows that this is despite the under 18 age group representing 17% of those arrested for notifiable offences since 2006/07. However, custody can have a traumatising effect on children (as indeed it can with adults) and the risks of self-inflicted death following release should not be downplayed.
- 7.8 Three 17 year olds who took their lives shortly after release from police custody have focused attention on the impact of detention on vulnerable young people:
- “Edward Thornber hanged himself in a park after being detained, and accepting a warning for possession of 50 pence worth of cannabis. He was mistakenly sent a court summons which was found near his body.”*
- “Joe Lawton was arrested for drink driving when driving home from a party and was kept overnight in Cheadle Police Station. He shot himself two days later and had the police charge sheet at his feet.”*
- “Kesia Leatherbarrow was held in the police station over a weekend from the Saturday until she was taken to court and released the following Monday. She was not seen by her family again before she was found hanging in a garden”.⁸⁵*

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- 7.9 These are all tragic cases with individual and unique circumstances, but some factors were the same, and they all demonstrate how detention can have a devastating impact on children. In all three cases the parents had not been informed of the arrests because they were not deemed to be children, despite the UN Convention definition of a child. As a result they were not entitled to have an appropriate adult with them at the police station. Change only came following a campaign by the families and a charity ‘Just for Kids Law’ which called on the Government to treat 17 year olds in custody as children. A challenge by Judicial Review subsequently led to a change in the law so that 17 year olds are now treated like other children in police stations⁸⁶.

Inspection criteria

- 7.10 The new HMIC inspection criteria for police stations, ‘Expectations of Police Custody⁸⁷’, published in April 2016, strengthens the inspection regime in respect of the detention of children. Paragraphs 22 & 23 state:

“Safeguarding issues concerning children are identified at the earliest opportunity, including at the first point of contact. Children are diverted from custody where possible. Staff understand and respond to the distinct needs of children, recognising levels of maturity and how physical, sexual and emotional abuse and exploitation might affect a child’s behaviour, and any subsequent decisions taken about their care and welfare.

“Children are not held in custody overnight, except as a last resort. Children are kept separate from those who might pose a risk to them. Where it is safe to do, children are not held in cells. Children are returned home to their parent/guardian. Where this is not possible and/or there are safeguarding concerns, there are effective arrangements with the local authority that cover the provision of accessible safe accommodation for children.”

- 7.11 In the 2012 version of these criteria, consideration of children was limited solely to establishing that police custody is not used as a place of safety for children under section 46 of the Children Act. It is to be hoped that the application of the fresh inspection criteria will result in a further reduction in the detention of children in practice.

Overnight detention of children

- 7.12 The issue of overnight detention of children in police custody is controversial. The law already acknowledges that police cells are unsuitable for children. The Police and Criminal Evidence (PACE) Act 1984 requires the transfer of children who have been charged and denied bail to more appropriate local authority accommodation, unless:

86 R(HC v Home Office) [2013] EWHC 982 (Admin)

87 <https://www.justiceinspectorates.gov.uk/hmic/publications/expectations-police-custody-criteria/>

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- “it is impracticable to do so or;
 - “in the case of a juvenile aged 12 or over, secure accommodation is required but is not available and other local authority accommodation would be inadequate to protect the public from serious harm.”
- 7.13 Yet despite this legal framework, the practice of overnight detention persists. In 2008 and 2009 there were 53,000 children aged under 16 detained overnight, of whom 1,674 were aged between 10 and 14. Figures obtained by the BBC for 2014/15 for forces in England only, show nearly 23,000 children detained – a significant and welcome reduction from nearly 43,000 detentions in England in 2011/12, but a very high number nonetheless⁸⁸.
- 7.14 Overnight detention sometimes results from denial of bail to children who could potentially be released to their own homes. It should be recognised however that even when denied bail, children should still be transferred whenever practicable. In a large proportion of cases therefore, overnight detention results from failure to transfer in accordance with statutory duties. This may be due to shortages in both secure and local authority accommodation; police officers seeking secure accommodation rather than non-secure options; a failure by the police to request local authority accommodation; or local authorities not accepting requests from forces.
- 7.15 Failures on the part of police and local authorities to comply with these statutory obligations have been highlighted by:
- Her Majesty’s Inspectorate of the Constabulary (*The welfare of vulnerable people in custody*, March 2015),
 - the All Party Parliamentary Group for Children (*“It’s all about trust”: Building good relationships between children and the police*, October 2014),
 - the Criminal Justice Joint Inspection and the Inspection of Youth Offending (*Who’s looking out for the children?: A joint inspection of Appropriate Adult provision and children in detention after charge*, December 2011) and
 - the Howard League for Penal Reform (*The overnight detention of children in police cells*, 2011).
- 7.16 A joint criminal justice inspection in 2011 found that:
- “In nearly two-thirds (33) of our case reviews no Local Authority accommodation was sought. Of these, we assessed that 67% would have been suitable for transfer to non-secure Local Authority accommodation but instead continued to be detained in police cells.”⁸⁹*

88 BBC News, “Child, eight, held overnight in custody,” 30th January 2016, <http://www.bbc.co.uk/news/uk-england-34884313>

89 <https://www.justiceinspectors.gov.uk/hmic/media/whos-looking-out-for-the-children-2011215.pdf>

7.17 The March 2015 HMIC report, *The Welfare of Vulnerable People in Police Custody*, found that:

“There was evidence of children being detained in custody overnight at all forces. An example in our custody record analysis included a 15-year-old boy, detained for over 39 hours after being arrested for criminal damage, with his time in custody spanning two nights. The boy was charged and refused bail but despite numerous attempts by custody staff, no alternative accommodation could be found.

“...A number of factors contribute to the difficulties in finding alternative accommodation for children to prevent them spending long periods in police custody. In part, the difficulty stems from the frequency with which police request secure accommodation when other types of accommodation such as residential or foster care might be more appropriate. Secure accommodation should only be used in exceptional circumstances and in cases where there is a serious risk of harm to the public or to the child. Consequently, a request by the police for secure accommodation may be met with the response that none is available.”

7.18 The Coroner hearing the inquest into the death of Kesia Leatherbarrow in 2015 reported the lack of availability of local authority accommodation to be a severe problem. His report stated that:

“...across Greater Manchester it is estimated that, until recently, in only 10% of cases where the police requested such a service from a local authority a bed was available. Attempts are being made to address this issue but at present the figure remains at approximately 20% and the Inquest heard evidence that this was, “not good enough”.

“Again the facts heard at this Inquest seem to suggest that children younger than 17 are at risk of being held longer in custody, longer than necessary due to a lack of appropriate facilities. The court heard evidence that the police are in the undesirable position of having to decide whether to detain (potentially unlawfully) or release them when they feel it may be unsafe to do so.”

7.19 The Government has responded to these concerns and plans to launch its *Concordat on Children in Custody* in 2017. This will take the form of detailed Home Office guidance aimed at getting the police and local authorities to fulfil their statutory obligations, and ultimately achieve a decrease in the number of children held overnight in police custody. In addition, the Policing and Crime Bill (going through Parliament at the time of writing) introduces a prohibition on the use of police stations as a ‘place of safety’ for children under the Mental Health Act 1983.

7.20 Another aspect of child overnight detention is that of children being detained on the basis of mental health concerns. The Home Affairs Committee Inquiry on Policing and Mental Health highlighted the continuing use of police cells for children detained under section 136 as wholly unacceptable. The report stated:

“The fact that children are still detained in police cells under section 136 reflects a clear failure of commissioning by NHS Clinical Commissioning Groups.”⁹⁰

7.21 This situation is a matter of great concern and needs to be addressed as a matter of urgency.

Appropriate Adults

7.22 According to the National Appropriate Adult Network (NAAN) an Appropriate Adult (AA) is responsible for protecting, or ‘safeguarding’, the rights and welfare of a child or ‘mentally vulnerable’ adult who is either detained by police or is interviewed under caution voluntarily. The role was created alongside the Police and Criminal Evidence Act (PACE) 1984.

7.23 The presence of AAs to assist children and other vulnerable detainees is hugely important. As INQUEST stated in written evidence to this review:

“Like access to medical care, input from an AA can make a difference to detainees in mental health distress or personal crisis, reducing the likelihood of self-harm and self-inflicted death following release.”

7.24 Research conducted for the Home Office by NAAN published in 2015⁹¹ highlighted shortcomings in the appropriate adult scheme for vulnerable adults. Although not directly relating to children, many of the concerns the research raised apply equally to children who are in local authority care or cannot rely upon family members to attend as AA. A high proportion of children in police custody fall into this category and require local authority accommodation to which they can be released.

7.25 These concerns included the fact that many vulnerable adults do not receive support from an AA or do not receive it throughout the custody process; there is a ‘variable quality’ and limited availability of AAs; and a lack of a, “clear and consistent national framework for local co-commissioning, with commissioning co-ordinated and informed by Health and Wellbeing Boards and Safeguarding Adults Boards”.

7.26 The lack of funding for AA schemes is a particular issue. The 2015 NAAN research concluded that:

“...the annual cost of ensuring full provision of trained AAs from organised schemes, throughout the custody process and across England and Wales, is estimated at £19.5 million (£113,000 per local authority). Current national spending on AA provision for adults is estimated to be in excess of £3 million per year.”

90 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf>

91 See executive summary http://www.appropriateadult.org.uk/images/pdf/2015_thetohelp_summary.pdf

Recommendations:

- Local Authorities should ensure that they have reasonable systems in place to guarantee that all police requests for accommodation, whether secure or non-secure, are accepted. Adequate funding must be made available for local authority overnight secure accommodation of children in police custody.
- Police training and inspection should focus on utilising non-secure accommodation for children other than in exceptional circumstances, where children pose a risk of harm to the public.
- Inspection findings on the continuing use of overnight detention should feed directly into a national framework that links to departments for health and local government.
- The use of police custody for children detained under section 136 should be brought to an end with all NHS Trusts required to make sufficient provision of health-based places of safety to meet this requirement.
- Increased funding is required for appropriate adult schemes within a national framework for commissioning. This should include improved training and consistency of Appropriate Adult services.

8. Other Vulnerable Groups

8. Other Vulnerable Groups

Introduction

- 8.1 In considering the needs of potentially vulnerable people in police custody, a serving police officer giving written evidence to this review made the following observation:

“I think it is important to treat everyone as vulnerable regardless of what group they belong to until you have managed to assess them.”

- 8.2 This simple, common sense position is perhaps all too easily forgotten. It is easier, and understandable, to make instant judgements about detainees, often based on years of experience. The need to dispassionately assess the vulnerability of all detainees needs to be considered from the outset.

“The need to dispassionately assess the vulnerability of all detainees needs to be considered from the outset.”

- 8.3 For example, when the police encounter someone with learning disabilities and difficulties, mental ill health or who is on the Autistic spectrum the need for a cautious, informed and empathetic approach may not be obvious to them. Sometimes the disability may not be apparent, and the actions of a vulnerable person might be misinterpreted by police. This can result in conflict and the use of force. The police require the necessary training and experience to identify the various conditions and circumstances that render individuals vulnerable while in custody and be able to respond to them accordingly, including through the use of de-escalation techniques (to defuse situations of potential violence and resolve them without the professionals resorting to the use of coercion or physical force.⁹²).
- 8.4 Vulnerable women of course face similar difficulties as vulnerable men, but they are likely to be affected more severely. These issues are addressed later in this chapter. The vulnerability of transgender individuals also needs to be addressed with great care and sensitivity.
- 8.5 As a general rule, vulnerable detainees should be diverted from custody at the earliest stage unless the seriousness of the alleged crime, threats to witnesses or the detainee’s

92 <https://mentalhealthcop.wordpress.com/2015/07/26/de-escalation-techniques/>

criminal record demands that they are kept in custody pending a court appearance. Liaison and diversion schemes are discussed in more detail in Chapter 4 (Mental Health).

Social communication and perception disorders

- 8.6 Other groups of vulnerable people that may be particularly affected by detention in police custody are those with social communication and perception disorders such as Autism and learning disabilities and difficulties.
- 8.7 People with social communication and perception disorders often face unique difficulties when they interact with the police. In many cases it may be that their disability is not apparent as it is not visible, and as such their behaviour or attitude towards the police might be misinterpreted. The Equality Act 2010 states that ‘reasonable adjustments’ must be made by those providing services to the disabled. This includes the police who therefore have a legal obligation to adapt their methods and approach when faced with someone with social communication and perception disorders.
- 8.8 This is dependent on the police being able to recognise such disorders. Serious incidents can arise as a result of inappropriate responses from authorities towards such people. The following INQUEST case study involved a life-threatening incident due to risk of drowning of a 16 year old boy⁹³.

“Z, who was a severely autistic and epileptic boy, was taken by his carers to the local swimming baths for a familiarisation visit. At the poolside, Z became fixated by the water and did not move. After about 30 minutes, the pool manager called the police. Officers were aware of Z’s autism but without consulting with his carers on the appropriate way to proceed one of them touched Z. He jumped into the pool and was lifted out, struggling, by the police officers. He was restrained with handcuffs and leg restraints and placed alone in a cage in the back of a police van. He suffered post traumatic stress disorder as a result of the incident. The Court of Appeal upheld a finding by the trial judge that the police had a duty to make reasonable adjustments to their usual policy on control and restraint and were liable for breach of the Disability Discrimination Act 1995.”

- 8.9 In this case the appeal court judge stated:

“[The police] are not doctors. But the important feature of the present case is that, even before they restrained ZH, they knew that he was autistic and epileptic. They knew (or ought to have known) that autistic persons are vulnerable and have limited understanding. Further, I see no basis for holding that the duty to make reasonable adjustments is not a continuing duty. In my view, the judge was entitled to reach the conclusion that he did on this issue. It was a decision on the particular facts of this case. I reject the submission that his decision makes practical policing unduly difficult or impossible”⁹⁴

93 ZH v Commissioner of Police for the Metropolis [2013] EWCA Civ 69

94 <http://www.bailii.org/ew/cases/EWCA/Civ/2013/69.html>

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- 8.10 There are parallels with this case and with those of restraint related deaths in the breakdown of communication and the use of restraint equipment. This is discussed in more detail in Chapter 2 (Restraint).

Epilepsy

- 8.11 The issue of epilepsy, which was cited in the above case study, is a related factor, as the onset of a seizure can affect the behaviour of an individual so that they may appear violent or anti-social. There also appears to be a correlation with depression. In written evidence to this review Epilepsy Action stated:

“Depression and epilepsy appear to be closely associated. Depression is considerably more prevalent among people with epilepsy as compared with the general population, with people with poorly controlled epilepsy especially reporting higher rates of depression. This is something that should be taken into consideration when a person with epilepsy is taken into custody, as it might make the individual more vulnerable.”

- 8.12 Epilepsy Action also cited a 2010 case of an epilepsy sufferer who was involved in a serious incident with the police following an epileptic seizure:

“This case details a man who suffered a seizure at a gym, and became violent in his post-ictal state, which led to the paramedics requesting police attendance. Subsequently, restraint and a Taser (sic) were used in order to handcuff the individual. He was then taken to hospital, where he was diagnosed with renal failure, which is thought to have been caused by the exertion against the restraint. We are in agreement with the IPCC Commissioner Ms Naseem Malik’s quote in the report: “The overriding concern remains that a medical condition exists that can prompt an individual to be in a totally disorientated state which can result in them being incredibly violent, yet the only option open to police officers in dealing with such an individual at present appears to be to deliver controlled violence.”

- 8.13 It must be acknowledged that police called out to deal with someone acting violently face a difficult and demanding task, often in a stressful and chaotic environment. It may not be obvious that an individual is acting violently because of the effects of an epileptic seizure, but the police need to be aware of all possibilities and respond accordingly.

Support card schemes

- 8.14 In order to assist the police in being able to identify someone with learning disabilities and difficulties, as well as robust training, there are other tools that may help. MIND’s report, *Police and Mental Health, How To Get It Right Locally* (2013) describes local schemes which help people to identify their disability and need for particular support to police officers and others:

“Lancashire Constabulary has developed the ‘E Card’, an emergency information card, which aims to assist people with disabilities to communicate with police or other emergency services. It is credit card sized and has space for the person’s name and photo, medical condition, details of an emergency contact person, and other useful information such as communication needs or requirements in an emergency. The E Card is free of charge and distributed via various channels including NHS mental health teams and Chorley South Ribble and Blackburn Mind. Around 10,000 people are already making use of the E Cards and they continue to prove popular with individuals and other support services across Lancashire.”⁹⁵

- 8.15 Forces should give serious consideration to rolling out similar schemes, if they are not already doing so. In the same way that people with diabetes carry emergency information with them in the event that they are taken ill, a similar, voluntary ‘E card’ for people with social communication and perception disorders, or medical conditions that can affect behaviour such as epilepsy, may help the police and other care givers adopt appropriate approaches and methods when interacting with them.

Women

- 8.16 Vulnerable women will face many of the same challenges in police custody as vulnerable men but they may also experience unique difficulties that the police and healthcare providers should take into account.
- 8.17 Women form only a small part of the overall number of people who will find themselves in police custody. They are also more likely to be experiencing custody for the first time than men. As a result, they may be unfamiliar with the custody environment and therefore more vulnerable. The environment of a police station tends to be male dominated in terms of detainees. A majority of custody sergeants and other staff are also likely to be male (although not overwhelmingly so). The effect that this might have on a detained and vulnerable woman needs to be recognised.
- 8.18 Women are also more likely to be primary carers of children than men. They may experience stress and anxiety due to separation from their children, exacerbated by the possibility of their children being taken into care as a result of any conviction. Such pressures can have the potential to worsen pre-existing mental health conditions.
- 8.19 Statistically, women are also far more likely to have experienced domestic violence and sexual abuse. A high proportion of survivors of such abuse end up in the criminal justice system, having to cope with the associated mental health issues and other vulnerabilities stemming from that abuse.

95 https://www.mind.org.uk/media/618027/2013-12-03-Mind_police_final_web.pdf

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- 8.20 There is also the effect of strip searches (occasionally forced) that may lead to trauma. In some cases all clothing is removed and a blanket or paper suit provided. Women who have clothing removed to avoid potential ligatures are already, by definition, extremely vulnerable.
- 8.21 There have been particular examples of failings by police in relation to detained women. The case of Martine Brandon was raised by Doughty Street Chambers in evidence to this review:

“In March 2016 an inquest jury criticised failings in the care of a woman, Martine Brandon, who took her own life when in a police cell in Southampton Central police station, finding that insufficient steps had been taken to protect her welfare. Martine was arrested in October 2014 after she was spotted in the street waving a large kitchen knife, and heard saying that an invisible demon and her sister were threatening to kill her. Although she was clearly a highly vulnerable woman in serious mental health need, she was arrested and detained in a police cell, and she was found dead after being held for 18 hours. There had been a catalogue of grave failures in her care, including wholly inadequate communication with her by custody staff, and with healthcare staff, and police had fabricated assessments to cover gaps in the paper trail.”⁹⁶

- 8.22 This case is all the more shocking given that suicides within police custody have been largely eradicated, meaning that effective processes and procedures were not adequately followed.
- 8.23 In December 2016 the HMIC report *PEEL: Police legitimacy 2016* discussed the issue of police abuse of authority for sexual gain, describing it as “a serious form of corruption that betrays the trust of the public – particularly of some of the most vulnerable people in society, such as victims of domestic abuse”. The report stated that:

“Our data collection identified 436 reported allegations of abuse of authority for sexual gain received, or received and finalised, by police forces in England and Wales during the 24 months to 31 March 2016. This number includes instances of multiple allegations against a single member of police personnel, and of multiple police personnel with single allegations against them. During this same period, 334 police personnel had allegations of abuse of authority for sexual gain made against them.”⁹⁷

96 INQUEST case study

97 <https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/peel-police-legitimacy-2016.pdf>

Homeless people

- 8.24 According to research conducted by Dr David Baker of the School of Psychological, Social and Behavioural Sciences, Coventry University, homeless people are disproportionately more likely to die in police custody.⁹⁸ In evidence to this review, Dr Baker stated:

“This underlines the importance of other public services working effectively with police in terms of outreach and welfare services. The growth of the homeless population suggests that police will increasingly come into contact with the homeless and that this issue may become more prominent in the near future.”

- 8.25 According to the Mental Health Foundation, homelessness and mental ill health go hand in hand:

“It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common.”⁹⁹

- 8.26 As such, it is inevitable that the police will have to deal with homeless people, given that dealing with mental health issues more widely has effectively become core police business. The College of Policing Authorised Professional Practice (APP) on conducting risk assessments of arrested people¹⁰⁰, states that factors which may indicate an increased risk of suicide or self-harm include homelessness. The vulnerability of homeless detainees means that police should always consider whether it would be more appropriate to divert to a health based place of safety.

- 8.27 The wide range of conditions and circumstances rendering a detainee vulnerable is extraordinarily challenging for policing in the 21st century and emphasises the sheer volume and complexity of knowledge and intellectual rigour now demanded of police officers along with a sound capacity for problem solving. This complexity needs to be recognised in the recruitment, training and development of police officers and their support staff.

98 Baker, D. (2016) *Deaths after police contact: Constructing Accountability in the 21st century* Basingstoke. Palgrave.

99 <https://www.mentalhealth.org.uk/blog/homelessness-and-mental-health>

100 <https://www.app.college.police.uk/app-content/detention-and-custody-2/risk-assessment/>

Recommendations:

- Mandatory police training on vulnerability must include understanding of, and appropriate policing responses to those with learning disabilities and difficulties, mental ill health, epilepsy or who are on the autistic spectrum as well as other conditions which may compromise the ability to communicate and understand police actions or processes.
- The use of support card schemes should be developed by all forces and included in police training.
- Police training should address the particular stressors that affect women detainees and young women in particular. Officers should understand the additional impact of these stressors upon women with mental health difficulties and the importance of access to healthcare.
- Custody procedures should be developed to lessen the impact of separation of mothers from young children. For example, supervised telephone contact around childcare issues should be prioritised and visits with children and their carers facilitated for longer detentions unless the nature of the alleged crime or the ongoing investigation prevents this. There should be monitoring of the extent to which police bail decisions take account of caring roles and the effects on the likelihood of absconding.

9. IPCC Investigations

9. IPCC Investigations

Introduction

- 9.1 The Independent Police Complaints Commission (IPCC) was created by the Police Reform Act 2002, and became operational in 2004, replacing the old Police Complaints Authority (PCA), which was an internal police body.
- 9.2 The IPCC oversees the police complaints system in England and Wales and sets the standards by which the police should handle complaints. It is independent, making its decisions entirely independently of the police and Government.
- 9.3 Specifically, the IPCC provides independent oversight of the police complaints system by:
- Overseeing the complaints system to ensure that complaints are handled correctly and identifying failings, leading to improvements in policing;
 - Considering appeals when people believe a police investigation into a complaint has got it wrong; and
 - Carrying out its own investigations into the most serious and sensitive matters relating to the conduct of the police.
- 9.4 The creation of the IPCC was a result of many years of campaigning for an independent body to investigate police actions. Such a body had been floated as far back as 1981 in the Scarman Report¹⁰¹. Before the IPCC it was common for deaths and serious incidents to be investigated by the force where the incident had occurred, with outside forces brought in to investigate the most contentious deaths. This was a system that did nothing to reassure families of the integrity or independence of investigations.
- 9.5 Despite significant improvements achieved through the creation of the IPCC, there is still a view amongst many families of those who have died in custody and of campaigners, lawyers and police officers who spoke to this review that the IPCC does not always feel truly independent of the police or of police culture. The report accompanying this review, *Deaths in police custody: A review of the international evidence*, found that similar concerns have been raised internationally with agencies that investigate the police.

101 *The Scarman Report: The Brixton Disorders, 10-12 April, 1981*

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- 9.6 This perception may or may not be justified, but it is vital that if an independent investigative body is to work, it must have the trust of families, and the full cooperation of police forces. INQUEST believes that while the processes and transparency of the current system are ‘incomparable’ with what came before, “the promise of a truly dependent investigative mechanism that commands the trust of families”, has not yet been met.

IPCC review of Article 2 cases

- 9.7 During 2012 and 2013 the IPCC conducted a comprehensive review of its work in investigating deaths (known colloquially as its ‘Article 2 review’). The review was set up as a result of growing disquiet about the way in which the IPCC was handling such cases. The IPCC published the outcome of this review in a final report, *Review of the IPCC’s Work In Investigating Deaths*, in March 2014.
- 9.8 The report included 61 actions that the IPCC would put in place to deal with the concerns raised by NatCen (see below), including ensuring that there are specific restrictions on investigators leading an investigation into a force where they have previously worked; providing training on bereavement awareness and the stages of grief to all investigators and commissioners; and involving families in developing the terms of reference for the investigation. The findings of the review also matched many of the concerns raised in Dr Silvia Casale’s review of 2013 into the investigation of the death of Sean Rigg in 2008. The IPCC therefore combined its action plan with the Casale recommendations.

NatCen research

- 9.9 In 2012, in preparation for its Article 2 review, the IPCC commissioned NatCen Social Research (NatCen) – an independent research organisation - to conduct research on IPCC cases involving a death, in parallel with its own wider review. NatCen reported in March 2014 at the same time as the IPCC published its own findings.¹⁰²
- 9.10 Key findings from the NatCen were that:
- “Concerns had been raised amongst IPCC staff that the Family Liaison Manager function was not sufficiently valued and resourced by the IPCC.*
- “The timing, nature and location of the IPCC’s initial contact with families was important and getting this wrong could damage relationships. Delays contacting family members could undermine confidence in the IPCC.*

102 IPCC investigations into cases involving a death, *Independent research report*, NatCen Social Research, March 2014

“The information provided by the IPCC to family members at the outset of the investigation did not always meet their needs and could leave them unclear about crucial aspects of the investigation.

“Family members said they required regular and meaningful updates on the progress of the investigation and appreciated when this had been provided. Family members who did not receive adequate information felt that the IPCC was reticent to share this because the quality of the investigation was poor or because the IPCC wished to conduct the investigation ‘in secret’.

“IPCC staff and family members were critical of impersonal forms of communication such as the monthly progress letter. The time taken by the IPCC to share information with family members was also criticised and providing partial information to family members was reported to have had negative consequences.

“Interactions between family members and the IPCC (staff and Commissioners) varied. One family member spoke positively about the personal qualities of their Family Liaison Manager and described them as compassionate, approachable and dependable. The support provided by the Family Liaison Manager was valued and delivered in a way which was sensitive to the family member’s needs. However other family members described their relationship with IPCC staff as characterised by a lack of sensitivity, respect and empathy, and individuals were described as ‘arrogant’, ‘nasty’ and ‘patronising’.”

9.11 Concerns were also expressed to NatCen about the independence of the IPCC.

- The employment of former police officers and staff at the IPCC was controversial and gave the impression that the IPCC was inherently biased toward the police service.
- The IPCC was seen as similar in culture and mindset to the police service and the boundaries between the police service and the IPCC were perceived to be ‘blurred’ both at an individual and organisational level.
- The IPCC routinely rely on police forces at ‘vital points’ during independent investigations, for example initial scene management and securing evidence.
- However – the opposite view was also expressed. The IPCC was reported to have failed to treat police officers under investigation fairly and impartially on some cases. There was reported to be a perception amongst some police personnel that the IPCC set out to apportion blame to the officer(s) involved before all the facts of the case had been gathered.

IPCC one-year-on report

- 9.12 In March 2015 the IPCC published an update on their action plan.¹⁰³ This ‘one-year-on’ report set out progress to date on the 61 actions they had set themselves. They reported progress in the following areas with regard to family engagement, stating:
- “To make sure that all our interactions with families during an investigation are professional, respectful, sensitive and responsive to families’ needs, we have delivered continuous professional development training on bereavement to all our investigators and commissioners...We have built bereavement training into the training package for all new investigators to make sure that they are aware of how a prolonged and lengthy investigation, as well as the coronial process, can affect the bereavement process.”*
- 9.13 The report also outlined how the IPCC are reviewing their family liaison model as part of the change programme. This is not scheduled to be completed until 2017, but in the meantime the IPCC has made some changes to their investigation protocols:
- “...to make sure that there is clear consideration of the needs of families, and that the family is involved in the investigation, as well as making sure that families receive as much information as possible about what happened to their family member.”*
- 9.14 New IPCC guidance to investigators includes “*offering families the opportunity to meet with IPCC staff and the case commissioner at the beginning of the investigation*”. It also states that this opportunity should be offered throughout the investigation.
- 9.15 The IPCC set out its new policy on family interaction as follows:
- “To enable families to raise any concerns they have with the progress of the investigation or the interaction with the IPCC, they are provided with the contact details of the lead investigator’s manager and when appropriate the manager will make contact with them directly. This allows the manager to deal with any issues as they arise. We have continued, wherever possible, to provide press statements to families before circulation so they can express any concerns with the content.”*
- 9.16 The IPCC also developed an information pack in consultation with INQUEST, which sets out details about the investigation process and the coronial process. This information pack is designed to complement existing IPCC literature and letters that they report are routinely sent to families during investigations (although families who spoke to this review described such communications as ‘ad hoc’).
- 9.17 In the one-year-on report the IPCC report that they had “continued to seek the involvement of families in developing the terms of reference for the investigation to make sure that they are as engaged as they can be, or want to be, in the investigative process.” This fulfils an important Article 2 obligation to allow families full participation in investigations.

103 Update on the action plan from the Review of the IPCC’s work in investigating deaths, IPCC, March 2015

9.18 The one-year-on report recognises:

- *“There is a need for more diversity in the workforce. Following the recent restructure of IPCC operations function, the most senior members of the management team, which includes a chief operating officer, director of investigations and two deputy directors of operations, are all from a non-police background.*
- *“The IPCC has undergone a significant period of recruitment which has increased their staff by 50% since January 2014. Of the new staff recruited there are 151 investigators. This has reduced the percentage of staff in the investigations directorate who have worked for the police from 40% (28% as police officers) to 34% (20% as police officers).*
- *“The IPCC has also developed its policy on conflicts of interest – for example having personal relations with those under investigation, or having previously been employed by the police force being investigated – which has introduced a clearer test for staff and Commissioners to report conflicts of interest. The revised policy came into effect in April 2015, and all staff were asked to update their conflict of interest records.*
- *“There is also a new policy on declaring previous employment with the police or other bodies under IPCC jurisdiction.”*

9.19 In written evidence to this review INQUEST commented on how the Article 2 review had affected the IPCC:

“Some improvements have followed the IPCC’s 2012/13 Article 2 review. It is less institutionally defensive; there are better lines of dialogue, more instances of misconduct and criminal investigations, greater and in some cases earlier engagement with the CPS, an improved approach to instructing experts, better consultation around press releases.”

9.20 However, INQUEST also observed that:

“The process of change has been disappointingly slow and significant concerns continue with the varying quality of investigations, a lack of consistency, insufficient evidence of internal learning and developed expertise, poor relationships with some families, delay, continued perceptions of bias and of a lack of independence.”

IPCC independence

- 9.21 The IPCC is in a delicate position, whereby it needs to be expert in and draw on the specific skills and expertise of those who have served with the police and have recent experience of carrying out criminal investigations. This is an obvious necessity, but one that leaves the IPCC open to criticism. As the IPCC itself recognises, it is critical to public confidence in the IPCC and in the wider complaints system that the perception of its impartiality is not compromised by a close or professional connection between the person leading an investigation and those being investigated.
- 9.22 However, this issue is wider than close professional connections between the police and IPCC. There is also a wider cultural and historic connection, whereby ex-police IPCC investigators may bring cultural assumptions and sympathies with them.
- 9.23 As INQUEST stated in the written summary of the Family Listening Days held to support this review:
- “There is a perception that the IPCC operate with the police to protect officers, that investigators tend to be made up of ex-officers who are working with ex-colleagues and this leaves the process feeling one sided or lacking true independence.”¹⁰⁴*
- 9.24 Family members spoke of their direct experiences in this regard:
- “When they first came in, the way they talked, we thought someone’s here to help us, but very quickly you realise, actually no, they’re on the side of the police. We had to get into the police station and get the photographs to show to the inquest. The IPCC should have done that.”*
- “At the pre-inquest hearing, they walk in chatting together, makes you feel they’re hand in hand.”*
- “The IPCC investigator wasn’t real; he was an ex-policeman who was a wall. We couldn’t talk to him, he was there to defend. It felt like he was protecting his job, protecting the Metropolitan Police.”*
- 9.25 There is a delicate balance to be struck between effective working relations between the police and IPCC, and keeping a professional distance during investigations, but IPCC staff should strive at all times to consider how their interaction with the police may appear to third parties.
- 9.26 In oral evidence given to this review, IPCC investigators stated that whenever they met with families of the deceased they were asked whether they used to work for the police. They would always stress their independence, and the fact that IPCC Commissioners cannot be former police employees. In their opinion, ex-police staff should not be barred from joining IPCC as they come with a wealth of investigatory experience, as well as ‘insider’ knowledge of how the police operate.

104 See Annex D

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- 9.27 According to IPCC investigators, the original hope had been that skills and experience accumulated by IPCC investigators could be passed on to new staff, meaning that learning would come from within, and it would not be necessary to recruit former police to these roles. For various reasons this did not happen as planned. In order to professionalise the IPCC, investigators who gave evidence to this review believe that more ex-police investigators are required, but that there is also a need for younger non-police recruits with contemporary experience.
- 9.28 In its one-year-on report the IPCC pointed out that the most senior members of its management team are all now from a non-police background. However for families it is the investigator who is the key individual. The one-year-on report states that following recruitment the percentage of staff in the investigations directorate who have worked for the police has reduced from 40% to 34%. This is a welcome reduction, but it should be noted that many of those will have the role of senior investigator who is responsible for the investigation, report and its findings. The one-year-on report also states:
- “To reduce the risk of a perceived lack of independence, the circumstances in which investigators can lead an investigation into a force for which they have previously worked will be restricted. The policy also restricts the likelihood of them taking any significant decisions relating to the course or outcome of that investigation, such as approving terms of reference or signing off final reports.”*
- 9.29 The IPCC set out the following potential exceptions to that rule:
- *“An investigation that requires specialist skills, knowledge or training unavailable elsewhere.”*
 - *“The role in which the ex-officer was employed was so junior, so brief, so distant in time, or so removed from the body currently under investigation that no suggestion of lack of impartiality could reasonably be drawn.”*
 - *“A member of staff is on call and is sent on an urgent referral – the member of staff should be re-deployed at the earliest opportunity, while maintaining the continuity and integrity of the investigation.”*
- 9.30 On 17 December 2015, the Government launched a consultation on *Reforming the Independent Police Complaints Commission: structure and governance*, which sought the views of the public and stakeholders on proposals to reform the governance arrangements of the IPCC¹⁰⁵.
- 9.31 One of the questions posed by the consultation was: Should there be some restriction on people with a policing background taking up posts as senior management employees of the IPCC?

105 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486700/20151216-IPCC_Governance_ConDoc-WEB-v6_o-UK_O__3_.pdf

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- 9.32 63% of respondents to this question considered that ex-police staff should be restricted from occupying senior positions within the IPCC and 7% of respondents considered that people with policing experience should not be permitted to work at the IPCC in any position.
- 9.33 The Government, in its response to this consultation¹⁰⁶, stated that as part of its reform of the IPCC it would:
- Place an absolute restriction on the Director General (DG) from having worked for the police in any capacity
 - Provide the DG with powers to restrict those that have worked for the police from roles within the reformed organisation
 - Require that the DG publish a list of roles to which these restrictions apply, and the nature of those restrictions
- 9.34 These changes are welcome but are yet to come into effect. It is crucial that, once commenced, the changes do not result in a corresponding loss of organisational memory as the new structures are put in place.

Deaths and Serious Injuries Unit

- 9.35 It is understandable that in the early years of the IPCC there was a need to recruit from police sources in order to quickly establish an immediate core of staff with sufficient skills and understanding of the working practices of police officers. The rate at which non-police investigative and management staff have been recruited and trained to allow the IPCC to move away from this dependency and build up its own skills, expertise and organisational learning and memory has been very slow but is now accelerating with the provision of additional resources.
- 9.36 As with the Police, recruitment of individuals with the requisite specialist skills for the very demanding and sensitive work carried out by the IPCC has proved very challenging given the costs of living, in London in particular. The IPCC has recognised that this dependency must continue to be reduced and are clearly taking steps to address this. The reforms and restrictions proposed by the Government on recruitment of police should also impact on the rate at which the reduction can be achieved.
- 9.37 In the meantime there are steps that could be taken to restrict the use of former police officers from involvement in these most serious and sensitive cases where death or serious injury is involved. It is recommended that a specialist Deaths and Serious Injuries Unit of the IPCC should be established for the investigation of such cases. These cases are the most serious cases dealt with by the IPCC and justify the establishment of an effective group of the most senior and expert officers who do not have a background in policing in England and Wales.

¹⁰⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/505839/20160307-IPCC_Governance_ConRep-v4.o-UK_O.pdf

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- 9.38 The Unit should be responsible for the full investigation of the death or serious injury in police custody and become involved in such cases from the first intimation of the death. Local IPCC officers may need to attend the scene of the incident immediately on notification of the incident from the police and these officers should be trained for such incidents. They should also be in constant contact with a senior member of the Deaths and Serious Injuries Unit for advice, guidance and instruction. Members of the Deaths Unit should attend immediately at the scene to support the local officer's initial actions and be briefed and provide directions en route. The investigation should be taken over by the specialist Deaths Unit on the immediate arrival of its officers.
- 9.39 Resilience and succession planning for the work of the Deaths and Serious injuries Unit should be supplemented by seconding officers from other parts of the IPCC to the Unit for development and training. The IPCC should also look within and outside of England and Wales for expert consultants and secondees from other investigative organisations who are also expert in the investigative, forensic skills required to investigate such serious cases, for example, from other investigatory organisations in England and Wales and from the Procurator Fiscal Service in Scotland and the Office of the Ombudsmen for Police in Northern Ireland.
- 9.40 A wider pool of expert witnesses can also be considered by looking beyond the immediate jurisdiction of IPCC. These organisations may also provide training opportunities for IPCC investigators, for example, in the attendance at the scenes of suspicious deaths, post mortem examinations, scenes of crime supervision, the interviewing of witnesses and investigative report preparation. Senior retired police officers from these other jurisdictions may also be helpful in assisting the training and mentoring of IPCC recruits more generally without the need to rely on police officers to investigate these most serious and anxious cases.

Family liaison and bereavement training

- 9.41 In written evidence to this review the IPCC further expanded on their 2014 review, and on how their direct interaction with families led to changes in their training:
- “As part of the review, INQUEST facilitated a family listening day. The advice provided by families was very valuable and as a result we identified several actions to try to improve the experience of families. This has included providing training on bereavement awareness to all IPCC investigators and commissioners, and re-writing the information that families first receive from us.”*
- 9.42 Families of the deceased can therefore play a significant role in improving training materials and processes. The families who spoke to this review signalled their willingness to be involved with training the IPCC, police and other bodies. The IPCC should continue to utilise their invaluable insights.

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- 9.43 As mentioned earlier in this chapter, the IPCC is currently reviewing its family liaison model as part of the change programme. The quality and timing of engagement with families immediately following the death and thereafter is critical to the confidence of the family in the effectiveness of the investigation.

“The quality and timing of engagement with families immediately following the death and thereafter is critical to the confidence of the family in the effectiveness of the investigation.”

- 9.44 The delivery of training on bereavement to all investigators and commissioners, as announced by the IPCC is very welcome. However, the one-year-on report stated in March 2015 that the IPCC was in the process of reviewing its family liaison model. Annex 1 of that report, which sets out a timetable for remaining actions, states that the revised timetable for this is April 2017.
- 9.45 Whenever the training model is complete it should take into account that specialist family support officers should also be attached to the proposed Deaths and Serious Injuries Unit. Such officers should be competent in bereavement support and have a comprehensive understanding of the wide range of issues involved in such investigations.
- 9.46 Prior to the completion of their review the IPCC has made some changes to their family engagement procedures. These changes include offering families the chance to meet with IPCC staff at the outset of, and throughout, an investigation; providing families with contact details of the lead investigator’s manager in order to raise any concerns they may have with the investigation. The IPCC has also stated its policy of providing press statements to families before circulation, and seeking to involve families in the development of terms of reference. This is to be welcomed.
- 9.47 The IPCC also signalled its desire to embed family liaison within its staff’s performance reviews:

“...we have included in all investigators’ performance reviews an assessment of their work with families. This reinforces the fact that effective engagement with families is a vital component of IPCC work. To monitor this, investigators reflect on their relationships with families at regular meetings with their managers and also include an assessment of the effectiveness of those relationships in updates to the case commissioner.”

Disclosure to families

9.48 IPCC staff who gave oral evidence to this review stated that the Family Liaison Manager (FLM) is entirely reliant on the investigators as to what information can be divulged and when. This often leads to frustration that the IPCC are not giving useful information. While there may be good legal or investigative reasons for withholding some information at the early stages of an investigation, these reasons need to be explained. Officers also need to ensure that such information is genuinely not capable of disclosure and ensure such meetings and liaison is meaningful for the family. In written evidence to this review the INQUEST Lawyers Group stated:

“In almost every case, the “harm test” – whereby investigators are entitled to withhold information that would otherwise be disclosable, pursuant to Regulation 13 of the Police (Complaints and Misconduct) Regulations 2012 if there is a real risk that disclosure would have a ‘significant adverse effect’ – is applied very restrictively and in reality in most cases families can expect to see nothing in the way of primary documents until the conclusion of an investigation.”

9.49 The IPCC acknowledged that there is a need to be more open about what they can and can’t divulge to families, and why. INQUEST believes that ‘fears of prejudicial impact if families receive access to documents can generate too much caution and inconsistency across cases’. This leaves families isolated and suspicious despite the occurrence of regular liaison. Such meetings can appear superficial and patronising to the next-of-kin.

9.50 This was reflected in the experiences of family members who spoke to this review:

“We would raise questions with the IPCC. When they come back we’d ask “have you got the answers” they’d say “no”. We made a complaint to the IPCC, because they’re not taking our questions seriously. We waited a month and are still no further.”

“The police wanted to disclose to us quickly. The IPCC said, “you can’t have it”, the police said “we did everything we could.””

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- 9.51 Similarly, despite the information pack produced with INQUEST, some families continue to experience a lack of clear and timely information about their rights and where to go for information and support. This includes crucial advice on the benefits of obtaining early legal representation and signposting families to INQUEST. For example, the experiences of family members who were not aware of their right to have their own pathologist at the post-mortem examination, or their right to seek a second post-mortem examination, is indicative of the need for individual as well as general early advice. This issue is addressed in more detail in Chapter 16 (Coronial System).

“Some families continue to experience a lack of clear and timely information about their rights.”

Pre-Interview disclosure

- 9.52 In a submission to this review, the Inquest Lawyers Group stated that police officers who are suspects in a death or serious incident will routinely be given disclosure of material before they are interviewed. Such pre-interview disclosure should be carefully limited. According to the IPCC Statutory Guidance to the police service on the handling of complaints, May 2015:

“Decisions as to what should be disclosed should be documented and made in light of the circumstances of the case. The interviewee is not entitled to disclosure of every document, but only those that the investigator considers appropriate in the circumstances of the case to enable them to prepare for interview. Public confidence could be undermined if the extent of the disclosure given could be perceived to give the interviewee an unfair advantage.”

- 9.53 This guidance is broader than that issued by the CPS for the interview of civilian suspects which states that interviewees should be given only enough information to “enable the suspect to understand the nature and circumstances of their arrest”. This apparent difference of approach between civilian suspects and police suspects, has been criticised by the Inquest Lawyers Group in evidence to this review:

“Clearly, the test for what would amount to appropriate pre-interview disclosure must depend on the particular circumstances of the case. The current position – that ‘welfare concerns’ or an unwillingness to treat police officers as suspects take priority over an overriding consideration of the integrity of the investigation – is of serious concern and must be reformed.”

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- 9.54 There is no hierarchy of rights in law for different types of suspects in this context. Police officers who are suspects should not be treated more advantageously than civilian suspects.

Length of IPCC investigations

- 9.55 Cases involving a death or serious incident in police custody are likely to be amongst the most serious and complex cases the IPCC have to investigate. They clearly demand the highest priority in terms of resources and expertise of the organisation. Complexity and seriousness should not in itself be an excuse for unnecessarily long and protracted investigations.
- 9.56 The March 2014 IPCC report, *Review of the IPCC's work in investigating deaths*, stated:
- “There is no doubt that a reduction in our resources and an increase in demand for our work have put a strain on the timeliness and sometimes the quality of our investigations. However, the concerns about how we undertake investigations are not wholly because of a lack of resources. Even within our current resources, we must provide the best service possible.”*
- 9.57 In written evidence to this review the IPCC further stated:
- “We recognise the concerns about the timeliness of our investigations, and the need to ensure that they are thorough and of good quality. The two clearly impact on one another, and sometimes, in order to ensure that we have covered all the issues, or because we are awaiting other evidence or proceedings, our investigations take longer than we, the family or those being investigated would like. Our new operational management system is focusing on both timeliness and quality, with more accurate performance measures and quality control processes.”*
- 9.58 Delays in investigating these cases only add to the distress of bereaved families. It also has an adverse effect on police officers, some of whom may find themselves in the limbo of indefinite suspension. In written evidence to this review the Police Federation stated:
- “One of the biggest frustrations of our members towards the IPCC is the time taken for investigations to be completed. It is not at all unusual for investigations, particularly those involving deaths and serious injuries, to take several years to reach outcomes and recommendations.”*

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- 9.59 To ensure the timeliness of investigations, interviews with police officers need to take place quickly and as soon as reasonably possible after the event so that events are fresh in the mind. It is not uncommon to have delays of weeks, months and longer, adding to the overall delay. Some of these delays are contributed to by police officers not providing their own written statement timeously. Clear timeframes would help to ensure that police accounts could be obtained at interview as early as possible. Additional interviews could be conducted at a later date if further lines of inquiry emerged during the investigation.
- 9.60 The causes of delay and problems with the quality of investigation may be addressed through the creation of a specialist Deaths and Serious Injuries Unit and a fundamental change in how such cases are investigated and supervised. Evidence was given to the review of how the Investigating officer in the IPCC tends to work alone with ad hoc assistance from others and supervision from a senior manager. The move to team based investigations that are not paused for illness, leave or training by one individual being absent, could accelerate investigations and improve quality. Supervision should be fashioned into the process rather than at present in a linear mode with comments received predominantly at the submission of the report.
- 9.61 The length of investigations could also be made more efficient with better and earlier cooperation with the Coroner, the Crown Prosecution Service and Health and Safety Executive. This is discussed further in Chapter 14 (Prosecutions).
- 9.62 The IPCC should consider the adoption of formal time limits in which to complete their investigations. Such time limits need to be realistic and take into account the complexity and scale of the investigation. The Chief Coroner for England and Wales has introduced a time limit of six months from the date on which the Coroner is made aware of the death for Inquests to conclude. Coroners who do not meet the target are obliged to write to the Chief Coroner to explain why. In the same way, IPCC investigators could write to IPCC commissioners, the Coroner, and family members to formally explain the reasons for ongoing delays and the need for an extension of time.

The immediate aftermath

- 9.63 The first hours following a death are crucial. Not only can they fundamentally set the shape and tone of an ensuing investigation because of the importance of evidence gathering, but the family experience of the entire process may be coloured by the way they are treated in these crucial hours.
- 9.64 When a person dies in police custody within a station the immediate priority is evidence preservation. The cell or block is locked down and becomes an evidence scene. The whole custody centre may be cleared if necessary. This is known as the ‘golden hour’ for the preservation of evidence. The IPCC should be informed as soon as possible by the police Professional Standards Department. Until the IPCC arrive to take over, the police are solely in charge.

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- 9.65 Similar considerations apply where the death takes place outwith a police station. While members of the public and potential witnesses may be present at or following the time of death, the police remain in charge of the preservation of the scene until the IPCC arrive.
- 9.66 There will almost inevitably be a delay between the death or serious incident and the IPCC representatives arriving at the scene to ensure that key evidence is preserved. Unlike the police service, the IPCC do not have a physical presence in all parts of England and Wales, and there may also be delays in notification by the police of any incident. Even if the police on the scene act with complete integrity, a lengthy gap before the IPCC arrive to take over the investigation can give rise to concerns about the opportunity for evidence loss or even tampering. It is therefore just as much in the interests of police officers as it is for families that the IPCC get to the scene as soon as possible.
- 9.67 While waiting for the IPCC to arrive at the scene, the police should not interview witnesses other than to obtain contact details of those who are departing or may depart from the scene. The integrity of the investigation could be fundamentally undermined if eye witness accounts from independent witnesses could be communicated to officers involved in the incident before they had provided their own accounts.
- 9.68 IPCC staff told this review that there has been a historic problem with delays in being notified of a death by the police (the gap between the incident occurring and the IPCC being notified is typically anywhere from 45 minutes to two hours, depending on the force), and the subsequent time it takes for the IPCC to arrive on the scene. There was acknowledgement that the IPCC needs to think about how it operates its out of hours on-call system, but it should be remembered that the IPCC is not a 'blue light' service.
- 9.69 The idea of having an independent person trained in crime scene management to get to the scene in advance of the IPCC was discussed during the review. These people would operate in much the same way as an 'on call' duty solicitor, whose role would be only to observe police activity at the scene of a death until the IPCC could formally take over. Such a person would effectively be looking after the interests of the deceased in the immediate aftermath of a death.
- 9.70 It was felt that this was a role that the Coroners' office once held when Coroners more routinely attended the scene of a sensitive death, as the Procurator Fiscal continues to do in Scotland. This would not be practical now given the resources of Coroners offices and it is not the practice of the Coroner to visit the scene of the death other than in highly exceptional cases such as the Shoreham air disaster. It was strongly felt by Coroners that they should not routinely attend the scene of a death in the immediate aftermath, as to do so would be to put themselves into the investigation as possible witnesses and thus compromise their independence. (They considered that visiting the scene with a jury at the time of the inquest is a different matter).

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- 9.71 Notwithstanding the question of who would be the most appropriate person to conduct such a role it does not change the fact that, even allowing for a potentially greater geographical spread than currently enjoyed by the IPCC, it would still be very challenging for any independent person to be present during the ‘golden hour’ itself. Potential police misconduct can occur in the first 30 seconds following a death, and an independent observer would still need to be notified of the death in a timely fashion. Ultimately the police have to be responsible for their own conduct at these very early stages following the death and the IPCC needs to be robust in holding them to account.
- 9.72 Rather than creating another level of bureaucracy between the police and IPCC, the IPCC should be resourced to ensure an experienced officer can attend as a matter of urgency at the scene. On arrival that officer should liaise with the Senior Police Officer in Charge and with the Coroner, direct early steps, act as an observer to ensure the integrity of the evidence and communicate with specialist officers from a new Deaths and Serious Injuries Unit as those officers make their way to the scene.
- 9.73 There are specific concerns around early evidence preservation during the golden hour. Probably the most visible and direct form of evidence from the scene will be CCTV footage. As an authoritative record of what occurred in any given incident it is not definitive, but it is nevertheless a significant source of evidence, both inside and outside the police station.
- 9.74 If cameras and audio recording equipment within police stations or vehicles are found to be faulty, families will be understandably suspicious that footage may have been destroyed or edited. It is just as much in the interests of the police that cameras are fully functional at all times. The experience of one family member indicates the frustration and suspicion that can occur when there is confusion around the use of CCTV at the scene:
- “We told the IPCC that we were certain these cameras existed because we had seen them ourselves - unbeknown to them at the time. The IPCC had to conduct an investigation into all the cameras at the station following a complaint from the family. Weeks later they told us that the cameras did exist, but had not been working for three months.”*
- 9.75 Conferral and separation of police officers following a death in custody is also a serious issue, and is explored in more detail in Chapter 10 (Police Conferral).
- 9.76 The collection of forensic evidence is also critical and proper scene preservation is crucial for the integrity of such evidence and to prevent contamination. The IPCC have independent 24/7 forensic contractors who can advise investigators, but the reality is that they are still reliant on senior police officers to manage the scene and preserve evidence before they arrive.
- 9.77 In addition, when a person dies in hospital and where there has been police involvement prior to the death, there is a need to ensure that toxicological and forensic evidence available while the deceased was still alive before transfer to hospital is not lost en route. This should be made available to the IPCC investigators subject to the permission of the doctor in charge.

Recommendations:

- Urgent consideration should be given to the development of an expert Deaths and Serious Injuries Unit of the IPCC for the investigation of all deaths in police custody in England and Wales. The Unit should be staffed by senior and expert officers from a non-police background.
- Ex-police officers should be phased out as lead investigators in the IPCC. To the extent that the IPCC still consider this expertise is required, ex-police staff should act as a consultancy and training source within and, more appropriately, outwith the organisation. The IPCC should also look beyond England and Wales for expert consultants and secondees from other investigative organisations who are also expert in the investigative, forensic skills required to investigate such serious cases, for example, from the Procurator Fiscal Service in Scotland and the Office of the Ombudsmen for Police in Northern Ireland. A wider pool of expert resources can also be considered by looking beyond the immediate jurisdiction of the IPCC.
- Written information about sources of specialist support, including information about INQUEST, should be given to every family at the very first contact with an IPCC representative, as well as alternative forms of this information taking into account the needs of the individual next-of-kin.
- IPCC staff should tell families immediately following the death of their loved one of the right to independent specialist legal advice, the benefit of securing advice from the earliest possible stage, and the right to seek a second post-mortem.
- This information should be regularly repeated during the progress of the investigation if the family have not sought legal advice at the earlier stage. The Coroner should provide information to families about the post-mortem examination before it takes place – including the time and location of the examination, and their right to have a representative present, and all other associated rights.
- IPCC staff should be vigilant about language and communication with families and of how their conduct and communication with police officers may be perceived by next of kin. Families should be invited to express concerns about anything said by IPCC staff which may give rise to doubts about independence. This should form part of the IPCC's learning and development around engagement with families.
- The roles of the Commissioner and the lead investigator need to be made clear to families in relation to all key aspects of the investigation from the earliest opportunity.
- The IPCC should urgently consider whether to adopt a formal time limit for the completion of Article 2 investigations, with the lead investigator obliged to set out in writing why any extension to this limit was required.
- The IPCC should be resourced to provide a 24 hour national on call 'post incident' team with sufficient national coverage to ensure immediate response and attendance at a death or life threatening injury in custody within the shortest

possible timeframe. Those attending should have experience of all steps necessary to protect a potential crime scene and secure evidence. The IPCC officer should be in constant contact with a senior member of the Deaths and Serious Injuries Unit for advice, guidance and further instruction until members of that Unit have arrived at the scene.

- Police forces should be held accountable at the most senior level for protecting the scene when there is a death or serious incident in custody and preserving evidence until the arrival of the IPCC. Any failure to fulfil this role should be treated as a misconduct issue. Failure to maintain CCTV cameras and audio recording equipment in good working order should carry a disciplinary sanction.
- Investigations should maintain a strong focus on obtaining independent evidence, including prioritising CCTV coverage, mobile phone video recordings and the existence of independent witnesses during the immediate aftermath of an incident as well as appropriate instruction of experts.
- Families should be involved on an ongoing basis in the provision of staff training in the IPCC, including training on the impact of a traumatic bereavement.

10. Police Conferral

10. Police Conferral

Introduction

- 10.1 Immediately following a death in police custody or following police contact, the police have the task of securing the scene of the death until the IPCC can arrive to take over the investigation. During this period, any police officers or police staff at the scene are potential witnesses to what has occurred. Until the arrival of the IPCC officers at the scene there is no procedure or mechanism to prevent informal discussions between the police officers about what has just occurred. It is important therefore for the IPCC to be in a position to attend at the scene of the death very swiftly.
- 10.2 In all investigations it is important to capture, as soon as possible, the individual accounts of any eye witnesses or witnesses of fact, uninfluenced by the recollections or perceptions of others. In cases not involving the possibility of fault on the part of police officers the approach the police take with civilian witnesses following an incident will, so far as possible, be to keep witnesses apart, ensuring the account given to the police is the fresh individual recollection of that witness, uninfluenced by the recollections of other witnesses to the same event.
- 10.3 The initial account given by police officers following a death in custody may contain just the bare facts. Unusually, a detailed statement does not follow immediately or soon after (College of Policing guidance states that staff should not normally make detailed statements immediately, but should leave them until they are better able to ‘articulate their experience in a coherent format’). These statements may not be provided to the IPCC for many weeks or months and are self-prepared. They are not therefore noted by a third party with the ability to pose questions to clarify the account being provided by the officer, as would be expected if the police officers were noting a witness statement from a member of the public.
- 10.4 Because of these circumstances, some lawyers with considerable experience of these cases suggested to this review that all officers in such cases should be interviewed under caution as soon as practicable after the death, the rationale being that without such conditions the chance of securing true and accurate evidence from officers is potentially compromised. However, this approach may be counterproductive as police officers in such circumstances may be advised by their own lawyers to say nothing other than “on the advice of my lawyer I have no comment to make at this time.”
- 10.5 It is proposed that unless there are reasonable grounds to suspect criminal activity about the actions of an officer, or officers, they should be interviewed by the IPCC as a witness as soon as practicable after the event and without reference to or conferral with other police officers or other witnesses. If, during the course of the officer’s statement

the status of the officer changes and the IPCC officer is forming a suspicion about the conduct of the police officer being interviewed, the police officer should be cautioned immediately and the interview should become one subject to the usual rights of any individual suspected of criminal conduct. Any statement obtained should be as detailed as practical and followed up with further interviews should additional matters require to be addressed.

- 10.6 A long-standing concern of bereaved families and campaigners is the impact on the reliability and credibility of the evidence where officers have conferred with each other in the immediate aftermath of a death or serious incident. This discussion may occur before and during the preparation of written accounts. Many deaths in custody occur either within the police station or where there are no independent witnesses. The medical evidence is unlikely to be able to establish, on its own, the precise nature of the events preceding the death, which is why accurate statements are so important.
- 10.7 Currently, the opportunity for police officers to confer with each other during a formal meeting occurs before the IPCC becomes involved. This means that the police force to which the officers belong is the only body supervising and enforcing the immediate post-incident procedures. Sometimes it can take several hours for the IPCC to arrive (see Chapter 9, IPCC investigations).
- 10.8 The appearance of, or opportunity for collusion or inadvertent contamination of recollection presented by these meetings can seriously undermine public confidence in the subsequent evidence of police officers. The longer those officers who are critical witnesses to the event remain together following the death, the greater the anxiety and suspicions by families and others that the evidence of individual officers has been inadvertently or deliberately fine tuned to accord with the evidence of their colleagues. The process is one which fundamentally undermines the confidence of next-of-kin in the investigation. The suspicion of malpractice, even if it does not exist, damages trust in the police and in the value of the investigation.
- 10.9 Even if conferral is not carried out with deliberate, malicious intent, it can result in innocent contamination of accounts which is harmful for the integrity of evidence. Once officers have recorded their accounts the statements will form a central feature of the entire investigation and inquest process.

“Even if conferral is not carried out with deliberate, malicious intent, it can result in innocent contamination of accounts.”

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- 10.10 In practice, informal conferral can and does take place as officers spend many hours together in the aftermath of a death or serious incident, both before and after the arrival of the IPCC, sometimes remaining together while they write their initial accounts before going off duty.
- 10.11 Early separation of officers, other in pressing operational circumstances, is the best way to ensure non-conferral in practice and in a transparent manner. This is in both the interests of the police officers themselves and the public in order to safeguard public confidence in the integrity of their evidence.

Separation of officers

- 10.12 The College of Policing has introduced a supervision requirement for firearms officers as a means of addressing such concerns about conferral. This arrangement involves supervision by senior officers from the same force. While this development is an improvement, it does not secure sufficient independence to meet family and public concerns.
- 10.13 Furthermore, it is not clear whether the supervision requirements extend beyond shooting cases to other deaths or serious incidents in custody and following the use of force. Some forces are applying this guidance to all deaths, but there is no national consistency. Supervision applies only from arrival at the police station, even though officers frequently spend a considerable time at the scene following an incident and travel back to the station together. The supervision also only applies to officers who have used force, not to officers who have witnessed the event but not participated in the activity leading up to the death.
- 10.14 The IPCC has issued draft guidance on post-incident procedures which advocates separation of officers (with certain caveats). This draft guidance is currently before the Home Secretary for approval. The guidance states that once the key policing witnesses have been identified:
- “From the moment it is operationally safe to do so, they should be kept separate until after their detailed individual factual account is obtained (para 20.3).”*¹⁰⁷
- 10.15 This is entirely sensible and reasonable guidance which will help protect the integrity of the evidence and assist the police in rebutting serious allegations or inferences of collusion.
- 10.16 If this guidance is approved it will not be binding on police forces, but they will be obliged to have regard to it¹⁰⁸. However, it would be highly unusual for police forces to ignore guidance from the IPCC which the Home Secretary has approved.

107 IPCC draft statutory guidance on achieving best evidence in death or serious injury matters 2014

108 Police Reform Act, 2002, Section 22(7)

Police non-conferral guidance

10.17 The current police guidance from the College of Policing states:

“As a matter of general practice, staff should not confer with others before making their accounts (whether initial or subsequent accounts). The important issue is to individually record what their honestly held belief of the situation was at the time of death. If, however, in a particular case a need to confer on other issues does arise, to ensure transparency and maintain public confidence staff must document that this has taken place. The record should include the:

*time, date and place where conferring took place issues discussed and with whom reasons for such discussion.”*¹⁰⁹

10.18 This guidance prohibits conferral in respect of what is in an officer’s mind at the time of the incident – their ‘honestly held belief’. It does allow for conferral on ‘other issues,’ a concept that is not further defined. The guidance also states that the police should:

“...arrange a critical incident debrief for staff involved after the officers involved have provided their initial account and the needs of the investigation have been met – it may be that this debrief only takes place following conclusion of the investigation.”

10.19 This debrief, after police have provided their initial accounts, allows a degree of conferral before the officers prepare their detailed statements. This arrangement has failed to address concerns on the part of bereaved families and the public about collusion or contamination of accounts if officers remain together and can, effectively, prepare accounts together.

10.20 Following the Mark Duggan inquest in 2014, the Coroner prepared a report to prevent future deaths in which he raised concerns that there was ‘considerable scope’ for conferral before any account was given, and that officers gathering in a room together for many hours to compile statements created a perception of collusion. He noted that this was in accordance with national practice sanctioned by ACPO but he believed it was not the best possible practice. He also noted that:

“a civilian who uses lethal force in defence of himself or another would not be given 48 hours to compose himself prior to being questioned by police, and it is not immediately obvious why a trained firearms officer should require what a civilian is not given.”

10.21 Although deaths by police shooting do not come within the scope or terms of reference of this review, there is considerable read across. The College of Policing APP on deaths in custody specifically cross-references guidance on conferral in the Armed Policing, Post Deployment APP, where the wording is virtually identical. The Coroner’s concerns about conferral in the Mark Duggan case are every bit as valid when applied to other deaths in police custody.

109 <https://www.app.college.police.uk/app-content/detention-and-custody-2/deaths-in-custody/#steps-that-should-be-taken>

Police view on conferral

- 10.22 One reason cited for discussions between officers following a death or serious incident is that officers may be traumatised and need support in the immediate aftermath. It is right that the police should have all their welfare needs addressed and have support from colleagues if necessary, including from Police Federation representatives. However, such support should not come from colleagues who were also witnesses to the incident.
- 10.23 In oral evidence given to this review, members of the Police Federation explained their understanding of the use of conferral. They were quick to draw a distinction between matters of belief (about which they would never confer) and matters of basic fact.
- 10.24 They explained that officers did not confer to get their stories straight, but to help ‘jog their memory’. During an investigation they have no access to CCTV records and might forget certain details. They considered that conferral on these details can therefore lead to better quality, more reliable statements. This explanation does not assuage concern about contamination of individual recollection. It is precisely the problem that undermines public confidence. ‘Jogging’ someone’s memory by conferral wholly undermines the independence and integrity of any account they subsequently provide.
- 10.25 The Police Federation members were clear that such discussion was important because there were adverse consequences for individual officers for failing to accurately recall such details. In their view the IPCC had ‘zero tolerance’ for any discrepancies in the accounts provided by police officers. They considered that such a rigid stance from the IPCC all but encouraged conferral.
- 10.26 The IPCC, in turn, are clear that conferral should never happen. In oral evidence given to this review IPCC Commissioners stated that minor discrepancies in accounts are normal and to be expected. They cited, by way of example, the murder of Private Lee Rigby. Despite some discrepancies, individual officers adhered to their initial accounts because it was a record of their honestly held recollection of events. This reflected well on the officers. By contrast, if police officers provide uniform or identical statements where there are absolutely no discrepancies, this may look more suspicious and be suggestive of a product of collusion.
- 10.27 Clearly there is a marked difference of opinion between the Police Federation members who gave evidence to this review and the IPCC about the consequences of officers providing statements containing discrepancies. It should be recognised that following chaotic and stressful incidents it would be entirely natural that officers may have variations in some aspects of their recollections of the events. Any significance to be attached to the differences in the accounts between individual officers will depend on the facts and circumstances of each case. This however should not be a reason for the police officers to confer with each other on such details. All statements must be the individual officer’s honestly held recollection of events.

“It should be recognised that following chaotic and stressful incidents it would be entirely natural that officers may have variations in some aspects of their recollections of the events.”

- 10.28 It should also be recognised that if officers were intent on perverting the course of justice by concocting a false or embellished account of the incident they will have the opportunity to do so even at the scene or privately. The opportunity can never be entirely eradicated. However, a system which formally condones officers being brought together when preparing their initial accounts is wholly unacceptable.
- 10.29 Increasingly, CCTV and body worn cameras may assist officers to provide evidence that is both credible and reliable but discussion with each other to reconcile discrepancies in their recollection places the officer in a perilous situation. Abandoning conferral is in the interests of justice and also in the interests of the individual police officers.

Court of Appeal ruling, 2014: R (Delezuch) v Chief Constable & R (Duggan) v ACPO

- 10.30 In 2014 the family of Mark Duggan challenged the ACPO guidance on conferral¹¹⁰. The family of Rafal Delezuch, who died following police restraint, challenged identical guidance adopted by Leicestershire Police. These two linked applications for judicial review were heard by the Court of Appeal.
- 10.31 In September 2014, a month before the Court of Appeal hearing in this joint challenge, the College of Policing (acting in place of ACPO) introduced revised guidance in relation to conferral and separation in its Armed Policing Approved Professional Practice (APP). The starting point remained that officers would not be separated unless a criminal offence was suspected. Instead, following arrival at the post-incident suite, they would be personally supervised by ACPO rank officers from the same force. The revised guidance states:

“Their responsibility for ensuring the compliance with guidance begins when the principal officers arrive at the post incident suite. It involves supervising those principal officers while personal initial accounts and detailed accounts are made (unless such accounts are provided during an interview or are recorded).”

110 [2014] EWCA Civ 1635

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- 10.32 It also stated that the appointed officer has a responsibility to explain the conferral guidance contained in the APP on armed policing to principal officers; to ensure that any conferral that takes place is compliant with the APP and documented by those in attendance at the conferral; and to prevent any inappropriate conferral (for example, related to an individual's honestly held belief at the time force was used).
- 10.33 At the hearing before the Court of Appeal the families argued that the new supervision arrangements, while welcome, were insufficient because:
- “There was no supervision whilst officers were at the scene of the death or during their journey back, or indeed even at the police station until they entered the post-incident suite*
- “The provision applies only to principal officers (those who have used force) not to witness officers*
- “The supervision is by officers from the same force not by an independent body such as the IPCC and so the perception may remain that non-conferring is not robustly enforced and the independence requirements of article 2 are not met” (INQUEST submission)*
- 10.34 In his judgment Lord Justice Richards dismissed the claims, stating that:
- “55 I accept that, in a case of death following the use of force by police officers, a failure to separate the police officers who used or witnessed the use of force may impair the adequacy of the investigation because of the risk of collusion (a term which I will use for the sake of simplicity to cover both dishonest collusion and innocent contamination of police evidence)....*
- “56 The approach taken in the IPCC’s draft guidance (para 23 above) has much to commend it from the point of view of article 2. The combined effect of the provisions relating to identification of the key policing witnesses (para 18 of the draft guidance) and those relating to the separation of such witnesses and the prohibition on conferring (para 20) would minimise the risk of collusion. The risk would not be eliminated altogether: para 20 provides for the separation of the key policing witnesses “[f]rom the moment it is operationally safe to do so”, which would still leave open the possibility of their discussing their evidence during the period when they were together for reasons of operational safety. That residual risk, however, could not realistically be avoided.”*
- “62 Overall, the 2014 guidance leaves open a greater risk of collusion than would be left open by the IPCC draft guidance, thereby creating a greater risk that an investigation carried out in accordance with the guidance would fail to meet the procedural requirements of article 2. But in the light of the safeguards that the guidance does provide, and bearing in mind that the adequacy of an investigation for the purposes of article 2 would have to be assessed by reference to all the features of that investigation, I take the view that the risk of breach of article 2 to which the guidance itself gives rise is a relatively low one. I do not consider it to be an unacceptable risk, such as would justify a finding that the guidance itself was unlawful.”*

10.35 Lord Justice Richards summarised ACPO’s arguments as follows:

“44 First, such an approach would be intrusive and stigmatising. Mr Chesterman, drawing on his extensive experience, expresses the view in paragraph 25 of his third witness statement that “requiring their separation from colleagues after a traumatic shooting regardless of the circumstances and effectively treating them as suspects (without, I observe, the protections afforded to criminal suspects) would be deeply unpalatable to many firearms officers and police officers considering applying for firearms duties”. He expresses the view that unless there are reasonable grounds to suspect otherwise, officers are witnesses and should be treated as such. Mr Beggs reinforces those observations by pointing to the likely effect on morale if officers have to be chaperoned from the scene and kept in separate rooms at the police station, presumably without mobile phones and/or subject to constant invigilation; all this on top of the traumatising effect that an incident involving firearms can have on the officers concerned.

“45 The second objection to separation is one of practicability. There are many instances where officers cannot reasonably be separated and may need to confer, for reasons that include safety, scene preservation, exhibit management and hot pursuit. There may be a large number of officers involved: for example, there were no fewer than 70 in the Saunders case, of whom 13 were initially regarded as principal officers, and numbers easily expand in terrorist situations. It would often be impracticable to chaperone officers individually to the police station and keep them in separate post-incident suites there. The claimants have allowed for exceptions for operational reasons, but the exceptions would become the norm.

“46 Thirdly, it is submitted that routine separation is unnecessary and disproportionate having regard to other checks and balances. The 2014 guidance deprecates conferring and this is underpinned by the disciplinary system, the supervisory structures (PIMs etc) and the discretion to separate with cause. Such concerns as remain will largely fall away if the use of body cameras by firearms officers, currently under trial, becomes established: provision can be made in the guidance for body cameras to remain switched on from the start of the incident until the point when officers enter the post-incident suite and are subject to supervision.

“47 Fourthly, it is submitted that there is no evidence that inappropriate conferring is a widespread problem. The vast majority of police officers are trained and decent professionals who will heed the warning against conferring. Separation is not required in their case. If, in the exceptional case, officers are intent on dishonest collusion, they are likely in any event to find an early opportunity to do so before any separation could be effected.”

10.36 In written evidence to this review, INQUEST put forward the following response to Lord Justice Richard's summary:

“Officers can be re-assured that they remain witnesses and not suspects, even with separation. The police hold a monopoly on the use of force on behalf of the state and this comes with a requirement to justify the fatal use of force in a transparent manner. They themselves will benefit from separation as it will prevent allegations of collusion. As police officers they will understand the need to preserve the integrity of evidence. Furthermore, if the IPCC decide, after reviewing the evidence, that their investigation will be conducted as a criminal investigation (e.g. in the case of Jermaine Baker this took place 7 days after the shooting) this will be after initial accounts have been provided and therefore to preserve integrity of the evidence all initial accounts should meet the requisite standards. Finally, if separation applies to all officers where force has been used, most commonly after restraint, firearms officers will not feel singled out.

“The overwhelming majority of deaths following police use of force (most of which are restraint not shooting cases) involve a handful of officers, commonly around 3 to 5, and there would be no problems of practicability in arranging for separation. Amongst police shootings the Mark Saunders case was highly unusual, the death having followed a lengthy siege. Incidents with a continuing pursuit of another suspect or involving terrorism are virtually unknown. The sensible approach would be for the guidance to require separation as a starting point with exceptions where this was impractical. It is simply not the case that the exceptions would become the norm.

“The guidance deprecating conferring has not created confidence on the part of families or the community so long as officers remain together and are able to confer. The supervision arrangements are insufficient for the reasons set out above. Body-worn cameras are proposed only for firearms officers but the vast majority of deaths following use of force are those involving restraint. During the Jermaine Baker shooting officers were not wearing cameras.

“There is evidence that lack of faith in investigations due to suspicions about collusion is long-standing and widespread. Materials placed before the court by ACPO contained confirmation that community trust in the police has been undermined. It is not sufficient to state that most officers can be trusted to act honestly, when lack of trust has always been at the heart of the issue. It is correct that it is impossible to entirely eliminate all opportunities for conferring, however officers spending many hours together before and whilst preparing their accounts is a different matter to a snatched conversation in the immediate aftermath if separation takes place within a very short time of a death.”

10.37 INQUEST also noted that officers' need for support and welfare considerations can be fully addressed in that they can be accompanied by any relevant person to meet those needs, so long as that person or persons were not eye witnesses to the relevant events.

10.38 The full judgement can be read here at :

<https://www.judiciary.gov.uk/wp-content/uploads/2014/12/r-delezuch-v-chief-constable-r-duggan-v-acpo.pdf>

International comparisons

10.39 Lawyers involved in the Delezuch and Duggan judicial review identified provisions for the separation of police officers in Canada and California.

10.40 In California the separation of officers is provided for through a Consent Decree, approved in *USA v City of Los Angeles, California, Board of Police Commissioners of the City of Los Angeles and Los Angeles Police Department*¹¹¹. Page 24, paragraph 61 states:

“All involved officers and witness officers shall be separated immediately after an OIS¹¹², and shall remain separated until all such officers have given statements or, in the case of involved officers, declined to give a statement; provided, however, that nothing in this Agreement prevents the Department from compelling a statement or requires the Department to compel a statement in the event that the officer has declined to give a statement. In such a case, all officers shall remain separated until such compelled statement has been given.”

10.41 In Canada separation is established in Ontario Regulation 267/10 *Conduct and Duties of Police Officers Respecting Investigations by the Special Investigations Unit*¹¹³. The regulation states:

“6. (1) The chief of police shall, to the extent that it is practicable, segregate all the police officers involved in the incident from each other until after the SIU has completed its interviews.

“(2) A police officer involved in the incident shall not communicate directly or indirectly with any other police officer involved in the incident concerning their involvement in the incident until after the SIU has completed its interviews.”

10.42 Los Angeles, within the jurisdiction of California, is not a low-crime area, and police shootings are not uncommon. If such a provision can exist there, and in Canada, it is a good indication that any logistical difficulties with the separation of officers can be overcome. This should apply equally for non-shooting deaths in police custody.

111 http://assets.lapdonline.org/assets/pdf/final_consent_decree.pdf

112 Officer Involved Shooting

113 <https://www.ontario.ca/laws/regulation/100267>

Recommendations:

- The IPCC draft guidance on post-incident procedures relating to separation of officers should be accepted by the Government.
- Other than for pressing operational reasons, police officers involved in a death in custody or serious incident, whether as principal officers or witnesses to the incident should not confer or speak to each other following that incident and prior to producing their initial accounts and statements on any matter concerning their individual recollections of the incident, even about seemingly minor details. As with civilian witnesses, all statements should be the honestly held recollection of the individual officer.
- The IPCC should make clear in its guidance that minor discrepancies in statements given by police officers or any other witnesses to fact, are natural and are not presumed to be the outcome of dishonesty or incompetence.
- Body worn cameras should be rolled-out nationally to all police officers working in the custody environment or in a public facing role. (10)

11. NHS Investigations

11. NHS Investigations

Introduction

- 11.1 Whenever a death or serious incident occurs in a National Health Service (NHS) setting following police contact, or where someone suffering a mental health crisis has come into contact with the police because of failures in mental healthcare services, there may be a need for an NHS investigation. NHS staff may also become involved in circumstances leading to restraint by police officers where, for example, ambulance personnel have been called out to the scene. Some deaths may follow a joint endeavour to restrain an individual by both police officers and NHS staff.
- 11.2 As a result, NHS Trusts may conduct their own investigation at the same time as an official IPCC investigation into the same death. There may also be related CPS and HSE involvement, as well as the Coroner's own overriding interest. This means that there needs to be excellent and early coordination between these bodies to avoid unnecessary delays, gaps in knowledge or evidence and to ensure the most effective investigations.
- 11.3 There is currently no formal independent investigatory body for deaths in healthcare facilities, including NHS hospitals and mental health detention settings. Whereas any police action relating to a death or serious incident can be investigated by the IPCC, there is no equivalent body looking at the actions of healthcare workers in the same circumstances. The Care Quality Commission is the independent regulator in England and has the power to monitor, inspect and regulate services, and can impose sanctions. While it does not investigate deaths in hospitals in England, it could issue guidance on how such investigations should be conducted.

“Whereas any police action relating to a death or serious incident can be investigated by the IPCC, there is no equivalent body looking at the actions of healthcare workers in the same circumstances.”

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- 11.4 NHS investigations are often internal, with the NHS Trust or healthcare facility effectively investigating itself. In its 2015 publication INQUEST observed¹¹⁴:

“There is a glaring disparity between the manner in which deaths in mental health detention are investigated pre-inquest compared to those in other forms of state custody. Unlike deaths in police, prison or immigration detention or following contact with state agents – where the Coroner’s inquest is based on the independent investigation of the Independent Police Complaints Commission (IPCC) or the Prisons and Probation Ombudsman (PPO) – no such equivalent investigative mechanism exists to scrutinise deaths in mental health settings. Instead, the inquest is reliant pre-inquest on the internal reviews and investigations conducted by the same trust responsible for the patient’s care.”

- 11.5 Deaths of patients detained under the Mental Health Act 1983 must be referred to the Care Quality Commission but it is the healthcare provider’s responsibility to ensure that there is an appropriate investigation, and what form that investigation takes.

NHS England

- 11.6 Under the terms of NHS England’s *Serious Incident Framework* (revised March 2015) “an unexpected death (where natural causes are not suspected) and all deaths of detained patients must be reported firstly to the Coroner by the treating clinician”. It must also be reported to the healthcare provider’s commissioners as a serious incident and investigated appropriately in circumstances where the cause of death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected.¹¹⁵ The framework states:

“In circumstances where the cause of death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected i.e. not caused by the natural course of the patient’s illness or underlying medical condition when managed in accordance with best practice - including suicide and self-inflicted death - then the death must be reported to the provider’s commissioner(s) as a serious incident and investigated appropriately. Consideration should be given to commissioning an independent investigation.”

- 11.7 The framework further states:

“In order to ensure independence and avoid any conflict of interest, no member of the independent investigation team can be in the employment of the provider or commissioner organisations under investigation, nor should they have had any clinical involvement with the individual(s) to whom the investigation relates.”

114 http://inquest.org.uk/pdf/INQUEST_deaths_in_mental_health_detention_Feb_2015.pdf

115 <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incident-framwrk-updz.pdf>

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- 11.8 According to NHS England, such investigations carried out under the Serious Incident Framework are conducted for the purposes of ‘learning to prevent recurrence’ only. They are not inquiries into how a person died, (as this is a matter for the Coroner) nor are they conducted to hold any individual or organisation to account.
- 11.9 Beyond the Coroner’s role in establishing the cause of death, there is no formal independent investigatory body, and the appointment of investigating teams remains ad hoc and largely at the discretion of commissioners.
- 11.10 The Department of Health also publishes advice¹¹⁶ which provides detail for NHS organisations on the factors to be taken into account when deciding whether an independent investigation needs to be carried out to satisfy obligations under Article 2 of the European Convention on Human Rights.

NHS Wales

- 11.11 In Wales, as in England, there is an obligation under the Coroners and Justice Act 2009 for Coroners to conduct an investigation where they have reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention¹¹⁷. These conditions could all potentially apply to a death in hospital, and the Coroner must be informed as a result.
- 11.12 In addition, there are arrangements in Wales for the management of complaints, claims and patient safety. These arrangements are called *Putting Things Right*¹¹⁸. They were developed in 2011, and require NHS organisations in Wales to report serious incidents involving patients to the Welsh Government. This would include deaths or serious incidents where the police were present and involved, but crucially is not independent of the Government.
- 11.13 NHS Wales also publishes guidance on the handling of serious incidents¹¹⁹. According to this guidance, a serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in (amongst other things) the unexpected or avoidable death, or permanent harm, of one or more patients, staff, visitors or members of the public.
- 11.14 According to the guidance, in the most serious cases, which would include those where there has been a death involving the police, a ‘comprehensive investigation’ would be required, and in some cases the incident may be referred for independent external review by Healthcare Inspectorate Wales, or other regulatory bodies.

116 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474020/Article_2_advice_acc.pdf

117 http://www.legislation.gov.uk/ukpga/2009/25/pdfs/ukpga_20090025_en.pdf

118 <http://www.wales.nhs.uk/governance-emanual/putting-things-right>

119 <http://www.wales.nhs.uk/sitesplus/documents/1064/Handling%20Serious%20Incidents%20Guidance1.pdf>

11.15 *Putting Things Right* has an emphasis on openness and engagement with families. In written evidence to this review NHS Wales states that:

“One of the main principles of PTR is that those who have any concerns are listened to, taken seriously and responded to in a timely way. We expect NHS organisations in Wales to support and engage with families and involve them in the investigation process if they so wish, as well as sharing the outcome of any investigation with them.”

Family liaison

11.16 Such an emphasis on liaising with families is welcome, given the negative experience of many families of those who have died following police involvement. When any decision is taken as to whether an independent investigation needs to be triggered, the views of the family should be listened to and taken into account, as well as those of the commissioner of the provider. It should be noted that independent investigations are likely to inspire more confidence from families and the general public than if NHS organisations were to essentially investigate themselves, notwithstanding the Coroner’s own investigation.

11.17 In written evidence to this review, Professor Keith Rix, a Consultant Forensic Psychiatrist, stated that families were often frozen out of the investigatory process in England due to, what he believes is a defensive mindset inherent in NHS investigations of serious incidents:

“The main problem I have seen is the closing of ranks and defensiveness so that, for fear of errors and mistakes becoming known to the families, they are kept out of the investigatory process. They should be involved from the outset in SUI [serious untoward incident] and similar investigations carried out by NHS trusts or other healthcare providers. It should be the norm for families to be involved in all aspects of these investigations.”

11.18 Family input should not only be sought by NHS Trusts prior to the commencement of an investigation, but throughout the investigation itself. The Care Quality Commission report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*, December 2016, stated that that “... families and carers have told us that they often have a poor experience of investigations and are not always treated with kindness, respect and honesty”. The report goes on to recommend that:

“Leaders of national oversight bodies (NHS Improvement, NHS England and CQC) and Royal Colleges, work together with families to develop a new single framework on learning from deaths.”¹²⁰

120 <http://www.cqc.org.uk/content/learning-candour-and-accountability>

Recommendations:

- Independent investigations should always be held for all Article 2 related cases on NHS premises where there has been police involvement, or where someone died after contact with the police.
- The Government should consider whether there is a need for a formal independent investigatory body for NHS Trusts in England and Wales.
- NHS Trusts should engage with families throughout their own investigations. There should be formal guidelines setting out the nature and expectations of family engagement.
- Where the NHS Trust is only one of a number of agencies investigating a death involving both police contact and NHS contact with the deceased there should be early, regular and formal communication and coordination with the IPCC and other agencies to minimise confusion, loss of evidence and delays.
- Where an individual dies during or following restraint involving both police and health personnel, a joint independent investigation by both the IPCC and the proposed independent investigatory body for the NHS should be closely aligned and coordinated in order to investigate the full circumstances of the death, including the conduct of the health personnel.

12. Police Custody: Medical Care, Inspections and External Agencies

12. Police Custody: Medical Care, Inspections and External Agencies

Introduction

12.1 It is vital that any joint working between the police and other agencies concerning the care and welfare of vulnerable people, runs smoothly and efficiently in order to minimise future deaths in custody. There have been occasions where failures in joint working have contributed towards deaths arising from custody, a critical issue that has been highlighted by both juries and Coroners at inquests.

12.2 In the death of Sean Rigg the Coroner who presided over the inquest observed in his Rule 43 (prevention of future death) report of 22 October 2012:

“What is clear is that despite the passage of four years since Mr Rigg died, there is still a lack of clarity and incomplete understandings of the roles of different organisations and when they should communicate and act together and especially in an emergency. I am convinced that there may be a continuing risk to patients who may find themselves in a similar situation to Mr Rigg in the future.”

12.3 There is a very broad range of circumstances in which lack of co-ordinated working and lack of communication contributes to or results in custody deaths. However, there are some recurring themes of particular importance which are discussed in this chapter.

Quality of medical care in police stations

12.4 Doctors working in police stations have a critical role to play. Their primary function is to address the health and wellbeing of the detainee, their patient. They are also obliged to gather evidence too, and, according to the Faculty of Forensic and Legal Medicine, explain to a detainee at the outset that they will record evidence as part of the examination. Doctors in the custody environment can provide a critical independent voice and treat detainees as patients first and foremost.

12.5 However, there have also been concerns expressed about poor quality medical care within police custody. These concerns have attracted criticism of healthcare professionals operating in the custody environment. Failures arise in the quality of medical care and lack of effective instructions to, and communication with, custody staff. The 2015 death of Sivraj Tharmalingam illustrates such failures:

“Mr Tharmalingam was seen by a Forensic Medical Examiner (FME) while in police custody. The consultation lasted less than a minute and the FME failed to make a meaningful connection with Mr Tharmalingam. The jury heard evidence that a

police detention officer remained present in the examination room throughout. The FME accepted that the examination was “cursory”. The FME was aware that Mr Tharmalingam was an alcoholic with epilepsy and yet did not look at Mr Tharmalingam’s medication or consider his previous custody records. The FME did not recommend a further medical review and relied on the fact that he had been interviewed by the police in concluding that Mr Tharmalingam was fit to be detained.”¹²¹

- 12.6 There are also Inquest conclusions that refer to failures by healthcare providers working for private medical services in police stations. These include a lack of training of their clinical staff on police practices such as the critical tests for police staff to carry out on detainees known as the ‘4Rs’ (Rousability; Response to questions; Response to commands; Remember illness¹²²) and a lack of clear protocols and information sharing between their staff and police staff. Medical staff employed by agencies may not have any continuity of experience or institutional memory.
- 12.7 There is no consistency in the profile of medical staff within police stations because different forces have different arrangements. It is currently the responsibility of individual Police and Crime Commissioners (PCC) to make these provisions. This inconsistency means the service provided in police custody may be effectively ad hoc and subject to a ‘postcode lottery’. According to Dr Jason Payne-James, President of the Faculty of Forensic and Legal Medicine (FFLM), quoted in the *Law Society Gazette*:
- “Some private commercial providers have placed advertisements for healthcare staff that require little or no previous experience in this setting. These offer a three-day training period before the professional starts work, unsupervised, in a complex, unfamiliar environment, with little or no mentoring or advice immediately available. There are already signs that NHS sexual assault services are not meeting agreed standards.”¹²³*
- 12.8 The March 2015 HMIC report on the *Welfare of Vulnerable People in Police Custody* concluded that:
- “Our inspectors observed considerable variation in practice across most elements of healthcare provision in custody. Some provision was excellent, for example, combined assessments between physical and mental health teams in Leicestershire.*
- “However, we also saw many examples of practice that raised concerns. There was lack of consistency in the quality and content of healthcare assessments across the six forces.”*
- 12.9 The British Medical Association (BMA) has also raised concerns about the varying levels of care across the UK, and has called for an improvement to the current standards since 2009¹²⁴.

121 <http://www.inquest.org.uk/media/pr/inquest-jury-concludes-that-failures-by-the-metropolitan-police-service-a-f>

122 See PACE Code C, Annex H, Detained person: Observation list

123 <http://www.lawgazette.co.uk/analysis/comment-and-opinion/false-economy-on-custody/5055251.article>

124 <https://www.bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/healthdetainees0209.pdf>

Custody Detention Officers

- 12.10 This review also heard evidence of concerns about the inadequacies of some custody detention officers employed by private companies. This included the way in which civilian Custody Detention Officers (CDO) perform their duties, as well as training provisions and management lines between CDOs and police officers, particularly custody sergeants.
- 12.11 Police Federation members in oral evidence given to this review, stated that Custody Sergeants are routinely assisted by CDOs. Indeed, nationally there had been calls for the Custody Sergeant to oversee a staff entirely made up of CDOs in order to free up police to do other duties.
- 12.12 Federation members were strongly of the opinion that functions should only be delegated to CDOs if there was confidence that they had the skills, training and experience to do the job. This was very difficult due to the high turnover of CDOs. The 2014 case of Martine Brandon, where two CDOs were found to have conducted unsatisfactory and inadequate checks before her death, was of particular concern to them.
- 12.13 The Coroner's Rule 43 report to the Assistant Chief Constable of Lancashire in 2012 (now known as prevention of death reports)¹²⁵ into the death of Bogdan Wilk stated that Group 4 custody staff had made 'a number of significant errors'. These errors were summarised in the report as follows:
- "i. When the custody sergeants asked for incoming property to be given to the Group 4 CDO, he assumed that this would be booked into the property log. This was not done by the Group 4 CDO.*
- "ii. When a doctor requested a Group 4 CDO to give him the patient's medication, the Group 4 CDO produced an open bag containing boxes of medication but neither checked the property log to see whether or not other sealed bags of property contained medication nor even contemplated producing a sealed bag to the doctor as "this contained personal property".*
- "iii. When the Group 4 CDO asked Mr Wilk if he was OK and he replied, "No, unwell," no further enquiry was made."*
- 12.14 The coroner went on to state:
- "I appreciate that these are Group 4 staff, but they work at the direction of the custody sergeant. I do not accept the submission by Group 4 that this is an isolated incident relating to one particular officer as, firstly no evidence was produced that this is not a systemic failing and secondly, in my experience failures of this type are rarely confined to one individual."*

125 Now known as Prevention of Future Death (PFD) reports

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- 12.15 In addition, at the Inquest into the 2014 death of Darren Lyons which concluded on 1 December 2016, the jury’s narrative finding “*was critical of the way observations were conducted in custody, the standard of handover information, and the service he received there from healthcare professionals*”¹²⁶. The IPCC concluded from its own investigation that “*some custody processes and policies were not correctly followed*”. Two custody sergeants and a CDO were found to have a case to answer for misconduct.
- 12.16 Privatised services in the police station need to be properly regulated if they are not to have the potential to increase risk for detainees. Efforts to introduce and implement national standards for training and monitoring are undermined by the disparate services provided across the 43 forces.
- 12.17 The majority of custody safety issues revolve around inadequate implementation of various custody safety procedures and, in particular, checks on detainees. If non-police employees working in the custody environment, including staff employed by private companies, fall outside of the efforts by the police force to improve compliance this will significantly diminish the impact on fatalities or accountability.

NHS Commissioning of healthcare

- 12.18 On any day of the week police stations across the country will have in custody individuals whose physical and mental health renders them very vulnerable. They will also have witnesses and victims of crime present whose health may be equally frail. The Government instigated advanced discussion and planning for medical services within police stations to be brought within the NHS, in the same way as they are in prisons. This would have allowed for a consistency of approach across the forces in England and also provide for minimum standards for medical staff within the police station – an objective that is potentially undermined by the current fragmented approach. Most importantly, it would enable access to NHS records of those in custody so that Forensic Medical Examiners would have access to a medical history of the detainee. Access to the medical history of the individual can be critical in deciding an immediate, appropriate medical response. As things stand, clinical practitioners and their patients are vulnerable in police stations as they cannot access full medical records.
- 12.19 NHS commissioning of healthcare in police custody was due to have commenced in April 2016, but was halted by the Government earlier in the year.
- 12.20 Every stakeholder who has spoken to this review has supported the NHS commissioning of healthcare in police custody. The Government’s change of mind is opposed by the Faculty of Forensic and Legal Medicine, a part of the Royal College of Physicians, and the BMA has warned that some of the most vulnerable people could be

126 <https://www.ipcc.gov.uk/news/ipcc-investigation-after-death-staffordshire-police-detainee>

put at risk by the decision¹²⁷. The Government needs to look again at this decision. It is recommended that the plans should be implemented as soon as possible.

Joint protocols with external medical services

12.21 A further recurring theme is the failure around the implementation of protocols and ‘crisis planning’ between the police and local medical services such as local hospitals, ambulance service, mental health detention and community mental health services.

12.22 Following the death of Sean Rigg in 2008, it was discovered that staff working at a hostel for those supported by mental health services in the community were unaware of joint protocols between the local NHS Trust and the police force. At the 2011 inquest into the death of Victor Massey the jury found that despite police being called upon to attend a hospital on a regular basis there was a lack of joint protocols on information sharing and dealing with incidents when police assistance has been sought.

12.23 Effective joint working can lead to good results as the HMIC found in its *Welfare of Vulnerable People in Police Custody* report in 2015.

“Where our inspectors considered the provision to be effective and safe, there was a systematic approach to healthcare assessment, and evidence-based guidance materials for healthcare staff were available. Healthcare practitioners recorded an initial screening to identify physical health, mental health, learning disability, substance misuse and self-harm risks. Safe systems were in place to manage medicines and make them available to detainees in a timely way. Consent was routinely sought for health interventions and for confidential personal information to be shared with partner agencies. This was recorded in the health record. Health staff had access to translation/interpretation services when required. Staff understood the importance of determining a detainee’s capacity to consent as set out in the Mental Capacity Act 2005. Healthcare staff checked with custody staff if an explanation was required, which enabled continuity of care.”

12.24 The key to providing a high quality service lies in establishing good working relations between local service providers and the establishment of clear guidelines and protocols to which there is adherence. The success of such protocols may often be dependant on strong leadership within the force, and developing excellent working relations with other stakeholders.

12.25 It should also be noted however, that such practices should not become reliant on the leadership and drive of individual relationships, as the departure of key people could lead to the collapse of a system that has been built up over time. Learning and institutional memory needs to be sustained (see Chapter 17, Sustained Learning).

127 <http://web.bma.org.uk/pressrel.nsf/wall/7F292609A7880F3580257F2C003B72E3?OpenDocument>

Independent Custody Visitors

- 12.26 Independent Custody Visitors (ICV) were created in the 1980s following the Brixton riots, as a result of Lord Scarman's subsequent recommendations.¹²⁸ Local ICV schemes recruit local people to visit and assess custody centres. They are administered by Police and Crime Commissioners (PCCs) who have a statutory responsibility to have ICV schemes in place for their force area. In England and Wales ICVs' powers are derived from the Policing Act 2002. The Independent Custody Visiting Association (ICVA) is a national body funded by the Home Office to spread best practice amongst regional ICV schemes and to provide a link to national policy.
- 12.27 In written evidence to this review the ICVA set out the scale of ICV activity:
- "ICVs provide a massive resource to deliver oversight of police custody. There are approximately 1,700 ICVs across England and Wales. ICVA has recently started collecting data on custody visits. This data is not complete, and the true scale of custody visiting is expected to be much higher. However, based on current data collection, ICVs in England and Wales conduct an estimated minimum of 7,000 visits to police custody and interview an estimated minimum of 24,000 detainees annually. ICVs will typically visit a custody suite once each week."*
- 12.28 In the event of a death in custody it should be possible to check whether an ICV visit was conducted in the run up to the incident. Visitors should also follow up on post-inquest recommendations to see if lessons have been learned. A volunteer therefore needs to be strong enough to ask robust questions. According to the ICVA:
- "ICVs can be invited into custody in the days following a death to deliver community reassurance. Following this, they can provide local oversight to ensure problems are not repeated, whilst a mechanism to share learning across all schemes could ensure that all areas benefit from lessons learned following a death."*
- 12.29 ICV schemes need to be recognised and valued for the vital role they play in helping to safeguard conditions within police custody. This means that they should have all necessary support required to collate and disseminate learning, and see it acted upon.
- 12.30 According to the ICVA, volunteers try to spread out their visits, in order to achieve a balance. Few visits however take place in the early hours of the morning, potentially the most vulnerable time for detainees. It is difficult to have a system whereby volunteers are compelled to conduct visits during antisocial hours, but policy makers need to address this problem or consider ways to encourage such visits. For example, some people work in shifts and the ICVA may want to target volunteers who can do night visits, providing safe transport to and from the station if required.

128 <http://hansard.millbanksystems.com/commons/1981/dec/10/scarman-report>

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- 12.31 In terms of governance, ICVs are now the responsibility of PCCs, who have a duty to run ICV schemes in their police area in England and Wales. Each PCC names a member of staff who is responsible for running the scheme and managing volunteers. In turn the findings of volunteers can be used by the PCC to hold Chief Constables to account.
- 12.32 It could be argued that the governance structure between the PCC and the ICVs is too close, as it does not appear to provide the necessary distance and independence from the police. It would seem more logical perhaps for ICV schemes to fall under the HM Inspectorate umbrella.
- 12.33 HM Inspectorate operates fully independently of the police. Her Majesty's Inspectorate of Prisons (HMIP) inspects police cells and court cells jointly with Her Majesty's Inspectorate of Constabulary (HMIC), against international human rights standards. HMIP use these standards to create sets of expectations for custodial settings.¹²⁹
- 12.34 HMIC tend to conduct data analysis, with HMIP conducting inspections in person usually with a 'blended team'. They typically look at the use of force and review CCTV, although force is rarely recorded and cross referenced with CCTV evidence. All HMIP reports are available online. All inspections are unannounced.
- 12.35 ICV volunteers occasionally take part in these inspections, so there is already an organisational relationship. The logical extension of this arrangement would be for ICV structures and processes to fall under the HM Inspectorate banner, although the day to day work, scope and duties should not change. Whilst there is no suggestion that ICV volunteers are unable to discharge their duties effectively under the current arrangement, the perception that the organisation might not be fully independent of the police whilst maintained by PCCs could be damaging. At the very least the Government should explore where ICVs should sit.

129 <https://www.justiceinspectorates.gov.uk/hmic/publications/expectations-police-custody-criteria/>

A change in approach?

- 12.36 No matter how good the provision of healthcare services in police custody is, or can become, irrespective of whether such services are delivered by private companies or by the NHS, the inescapable fact remains that these services are provided within the custody environment for some of the most vulnerable individuals in our communities.

“These services are provided within the custody environment for some of the most vulnerable individuals in our communities.”

- 12.37 In written evidence to this review, academics from the School of Psychological, Social and Behavioural Sciences, Coventry University; the School of Humanities and Social Science, Liverpool John Moores University; and the Faculty of Social Sciences of The Open University jointly stated:

“If the issue of death in police custody is re-imagined as a healthcare/public health issue, this would remove those with mental health issues, drug or alcohol dependency, and those who are homeless from a custodial environment and place them in a setting where their needs can be appropriately met. It is likely that this will be more effective in terms of the preservation of life.”

- 12.38 The main focus of the police and other agencies should therefore always be to divert the most vulnerable people from police custody at the earliest stage possible (depending also of course on the seriousness of the crime for which they have been detained). The Government has a responsibility to ensure that the police and healthcare providers are properly resourced to do so and that the most effective disposals become more readily available.
- 12.39 The use of Liaison and diversion services and Street Triage to keep the most vulnerable out of police custody is discussed in Chapter 4 (Mental Health).

Recommendations:

- Forensic Medical Examiners and other medical services within police stations should be brought within NHS commissioning, in order to introduce minimum standards of medical care in police custody and so that medical records are quickly available to the doctor.
- Privatisation of detention services should be avoided. Where private service providers are used the training of their staff should be to the same standards, preferably carried out jointly with police staff. They should be subject to the same processes of inspection and monitoring as police staff to ensure all-round compliance. Protocols between private service staff and police staff should be fully embedded and employed in practice to avoid fragmentation of services.
- Local joint protocols should be in place between all forces and their local ambulance service, mental health services and hospitals around 'crisis planning', particularly in respect of detainees suffering a mental health crisis and/or disturbed behaviour. Implementation of the protocols should be reviewed regularly and all staff must be familiar and confident in the practices required by the protocols.
- The Government should consider whether Independent Custody Visitor schemes should have governance within HM Inspectorate.

13. Police Misconduct

13. Police Misconduct

Introduction

- 13.1 The vast majority of police officers conduct themselves with integrity at all times, often during very challenging conditions. However, where things do go wrong, the public have a right to expect that the actions of police officers are properly investigated, and where there have been failings on the part of the police, that these will be dealt with appropriately. Some disciplinary conduct will be the subject of investigation by Police Professional Standards' departments within the relevant force but those which are of a serious nature, including the most serious of all involving deaths in police custody, must be investigated by the IPCC.
- 13.2 From the perspective of many families who gave evidence to this review there has been a longstanding failure by authorities to hold the police accountable for their mistakes or wrongdoing. There is a very strong perception that police sit above the law, and that a different set of rules apply to them. In oral evidence given to this review, families also expressed their bewilderment about the disciplinary process:

“Officers are still keeping their jobs. They are not being suspended or their duties limited whilst the investigations are taking place. Families are not informed but most believe that it will be nothing more than a ‘slap on the wrist’. They also try to retire to avoid action. They know that they can get away with it.”

“There is a very strong perception that police sit above the law, and that a different set of rules apply to them.”

- 13.3 Disciplinary action against police officers, and decisions not to instigate such action, must be transparent in order to safeguard public confidence, and to give greater certainty to the police themselves. Officers need to know as soon as possible if they are to face disciplinary action but often they may be left in limbo due to lengthy IPCC investigations.

Conduct investigations

- 13.4 The IPCC has the power to investigate a death or serious incident in police custody either as a ‘Death or Serious Injury’ (DSI) investigation, in which the police have the status of witnesses only, or as a potential disciplinary or criminal matter (a conduct investigation) where one or more police officers is the subject of the investigation.
- 13.5 Conduct investigations are rare even though the threshold for such an investigation is relatively low. In order to proceed with a conduct investigation there must be reasonable grounds to suspect that a disciplinary or criminal offence may have been committed. Some campaigners believe that there is reluctance on the part of the IPCC to consider criminal or disciplinary offences in contrast to the treatment of civilians, who, they believe, are more likely to be subject to a criminal investigation by the police if they meet the same threshold.
- 13.6 INQUEST cites the case of Olaseni Lewis as an instance where the IPCC failed to consider a conduct investigation. Mr Lewis was 23 years old at the time of his death following prolonged restraint at the Bethlem Royal Hospital in South London on 31 August 2010 involving 11 police officers.
- “From its outset, the original IPCC investigation into Seni’s death sought to rule out the possibility that the circumstances might disclose disciplinary or criminal wrongdoing on the part of the officers involved in the fatal restraint. As a result, the relevant officers were treated as mere witnesses rather than the subjects of the investigation: they were not put on notice that their conduct was under investigation, nor were they questioned in interview, under caution or otherwise. In the event, their accounts of the relevant events remained untested, and on that basis the investigation concluded in August 2011 where it had started, i.e. a determination that the circumstances of the death did not disclose any disciplinary or criminal wrongdoing on the part of any officer.”*
- 13.7 However, it should be acknowledged that there have been recent examples of the IPCC making brisk decisions to instigate conduct investigations within days of a death, including the cases of Leon Briggs and most recently, Dalian Atkinson. Such instances demonstrate that the IPCC does have the ability to act swiftly and make timely decisions. Indeed, there is increased recognition on the part of the IPCC of the need to take a more robust approach to decisions on conduct investigations.

Witness statements and interviews

- 13.8 There is a view that when the IPCC is investigating a potential criminal offence they should interview all officers under caution, including those treated as witnesses, not just those where there is a suspicion of criminal wrongdoing. This may be a double edged sword. A police officer under caution is a suspect with a right to silence and may be more likely to refuse to answer all questions on the advice of their solicitor. It may be harder for IPCC investigators to obtain meaningful information as a result.

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- 13.9 Typically, police officers who are treated as witnesses give an initial general and basic statement and weeks or months later provide a self-prepared detailed statement without IPCC officers being able to pose pertinent questions. The statement may also be prepared following conferral with the other officers present at the scene of the death.
- 13.10 Following the provision of written statements, police officers can be questioned by the IPCC as witnesses. In such cases there should be a duty of candour for the police to answer all questions based on their honestly held recollection of events. It may be argued that this duty of candour is an obligation under Article 2 of the European Convention on Human Rights which requires parties to positively assist the state in conducting thorough and effective investigations.
- 13.11 The 2013 Home Affairs Committee on the IPCC¹³⁰ stated bluntly that there should be more interviewing of police under caution:
- “The issue of interviewing officers in cases involving death and serious injury is indicative of a culture of treating officers differently from members of the public. Where officers are not interviewed promptly under caution, this can lead to weaker evidence and loss of confidence in the process of investigating serious matters such as deaths in custody. The application of the threshold test for special requirements should be reviewed, so that officers are routinely interviewed under caution in the most serious cases, exactly as a member of the public would be.”*
- 13.12 However, it should be recognised that members of the public who may have witnessed or have evidence about an event are not questioned under caution unless they are at least under suspicion of committing a crime, and the same should apply for police officers. There should be prompt interviewing under caution if and when there are reasonable grounds to suspect police officers of committing an offence. It may not always be apparent at the commencement of an investigation whether there has been a crime or if a particular officer is in any way implicated in an incident simply by dint of having been present along with other officers.
- 13.13 Interviews, either under caution where there is suspicion of criminality by the officer, or more generally when the police are deemed, at that stage, to be witnesses, must be carried out promptly by the IPCC, as any delay has the potential to weaken the prospects of securing reliable evidence. There should be strict timeframes to ensure that interviews are conducted as soon as possible. Subsequent interviews could be conducted at a later date if required.
- 13.14 Just as it is incumbent on the IPCC to carry out prompt interviews, the police also have a duty to provide statements in a timely manner. IPCC staff during their evidence to this review spoke of police officers delaying in submitting full written statements. Providing a full and candid statement at the earliest opportunity should be part of the police officer’s duty unless they are a suspect. If an officer is under suspicion of committing a possible crime he or she is entitled to the same rights in law as any civilian suspect.

130 <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/494/494.pdf>

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- 13.15 Consideration should also be given to such statements being given to the IPCC in response to questioning by the IPCC investigator rather than written up in private by the officer in his own time. It makes no sense that the IPCC cannot question officers who are not under suspicion at the earliest practical time to obtain as full a statement as possible. If during the course of providing the statement suspicion arises on the part of the IPCC investigator that criminality may be possible in the officer's account, of his own actings the interview can be halted immediately and the officer cautioned.

Resignation and retirement

- 13.16 Nothing can do more to undermine confidence in the police than for families to see officers resign or retire as a means of avoiding investigation. In some cases, families had no notice of the resignation or retirement, and did not find out until long after the event.
- 13.17 The Home Secretary has recently introduced legislation to Parliament that will prevent officers resigning or retiring early to escape being held to account for their actions unless they are medically unfit or there are other exceptional circumstances.
- 13.18 The changes proposed by the provisions of the Policing and Crime Bill will mean that where an allegation amounting to gross misconduct comes to the attention of a force soon after an officer has resigned or retired, they will be under a duty to investigate. Where there is a case to answer, a disciplinary hearing will take place.
- 13.19 Through these reforms, if an officer resigns or retires early during the course of an investigation or before a disciplinary process for gross misconduct has concluded, that process will be able to continue to a full conclusion. If found guilty, the officer will be 'struck off' from policing, through the introduction of the 'Police Barred List' in England and Wales. The information in the list will be shared with police forces and other law enforcement bodies to assist with vetting and recruitment. The Government should ensure that this list is also available to Police Scotland and the Police Service of Northern Ireland.
- 13.20 These are welcome reforms, and the Home Office should continually monitor their implementation to ensure that they work in practice, and that the new provisions are applied.

Suspension

- 13.21 Police officers are rarely suspended when facing investigation or misconduct charges, but may be redeployed to non-public facing roles. In some cases, by the time a case is resolved, an officer may have been promoted during the course of the investigation. Such occurrences do nothing for public confidence in policing. Forces may also ignore IPCC recommendations to suspend officers.
- 13.22 Forces are entitled to take decisions based on local circumstances and may be able to justify a decision to promote officers under investigation (especially in the event of an unreasonably long investigation). In such cases the police should be prepared to explain their decisions with sensitivity and empathy, and with all due respect to the investigatory process.
- 13.23 From the perspective of the police, the impact of lengthy IPCC investigations and the delay in decisions on whether to bring misconduct charges can be devastating to an officer's health thus making avoidance of delay critical for both the families and the officers concerned in the investigation. Forces may therefore be reluctant to suspend officers in the knowledge that contentious cases can take years to resolve.
- 13.24 Therefore it must be incumbent on all investigatory bodies to complete their investigations as quickly as possible, as it is manifestly unfair for officers to face the uncertainty of suspension for prolonged periods of time. Given the seriousness of deaths in custody, such cases should be dealt with in the same timescale as civilian homicide cases. The appropriate resources must be deployed by all agencies to achieve the completion of the investigation and decision making processes within the robust timescale achieved in those cases.
- 13.25 In addition, the IPCC should consider making a formal written request for the restriction of duties (in misconduct investigations) and the suspension of officers pending the outcome of gross misconduct and/or criminal investigations if the police have not already taken this action. The need for such action should be considered by the IPCC throughout the investigation, depending on the emergence of new evidence, and not simply considered at the outset.

Misconduct or gross misconduct

- 13.26 There is an important distinction between misconduct and gross misconduct in the gravity attached to a finding of gross misconduct. Police officers can only be dismissed from their job if they are guilty of the latter. Yet despite this, it remains unclear to police officers who gave evidence to the review as to what the definition of each is, and whether the criteria are applied consistently by the IPCC.

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- 13.27 This leads to uncertainty for the police. Members of the Police Federation who spoke to this review stated that in their experience, when conducting an investigation, the IPCC would ensure that officers always had the spectre of ‘gross misconduct’ – and therefore, a possible sacking – hanging over them. This would leave officers feeling they had little choice but to follow legal advice to say as little as possible. In their view, a more proportionate initial assessment of misconduct would allow officers to be more forthcoming.
- 13.28 The facts and circumstances of any individual case must be considered in light of the emerging evidence. Some deaths may arise from negligence and some from gross negligence amounting to homicide. There cannot be a ‘one size fits all’ case categorisation without there being a wholly arbitrary outcome which ignores the level of culpability in the cause of the individual death.
- 13.29 The official definitions of misconduct and gross misconduct were set out in the Policing and Crime Bill at the time of writing¹³¹ as follows:
- “Misconduct:** *Defined as a breach of professional standards*
- “Gross misconduct:** *A breach of professional standards so serious that dismissal (being sacked) would be justified.”*
- 13.30 Professional Standards are set out in Chapter 1 of the Home Office guidance: *Police Officer Misconduct, Unsatisfactory Performance and Attendance Management Procedures*¹³². These standards include honesty and integrity; use of force; and discreditable conduct. Breaching these standards may be caused by such allegations as dishonesty, gross negligence, perverting the course of justice, wilful intent and concealment. The IPCC Statutory Guidance of May 2015¹³³ states:
- “In deciding whether to indicate that, in their opinion, there is a case to answer for misconduct or gross misconduct, the investigator must consider whether the alleged misconduct, if proved, would amount to a breach of the Standards that is so serious as to justify dismissal and if so, should indicate that, in their opinion, there is a case to answer for gross misconduct. If not considered this serious, then the investigator should indicate that, in their opinion, there is a case to answer for misconduct only. The investigator should make clear in the report the reason why the particular case to answer finding has been reached.”*
- 13.31 In all cases the facts and circumstances will vary and levels of culpability may therefore differ between different deaths in custody and between the individual officers concerned in causing the death in any one instance. Investigators must be free to determine the level of culpability based on individual facts in relation to each officer

131 <http://www.publications.parliament.uk/pa/bills/cbill/2016-2017/0003/en/17003en15.htm>

132 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434377/misconduct-performance-attendance_v4__1__1_.pdf

133 https://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/2015_statutory_guidance_english.pdf

and on whether they were acting together in the act or failure that caused the death. Decisions on how such conduct should be characterised should take place in the context of a clear and specific set of professional standards as a framework along with the existing law applicable to all citizens irrespective of their status as a police officer.

- 13.32 However, in the interests of transparency and public confidence it would be useful to have greater specification about the criteria used by investigators to make their decisions. Such decisions are of such importance to the families of the deceased, to the police officer whose actions are under consideration and to the public interest, that the decision on what categorisation the alleged conduct falls into should be taken by the Director of a specialist deaths investigation unit rather than by the lead investigator (see Chapter 9).

Family engagement

- 13.33 Police misconduct hearings are effectively an internal tribunal where an employer examines the conduct of an employee or employees. It would however be naive to assume that they could be treated in the same way as any other employment tribunal by a private or public firm. The very concept of policing by consent demands a more transparent approach.
- 13.34 It is for this reason that since 1 May 2015, misconduct hearings have been held in public, and from 1 January 2016, they must also have an independent, legally qualified chair. These are good reforms that should help to increase public confidence in the process. However, the engagement of families with these hearings should not be forgotten.
- 13.35 If a misconduct hearing is brought at short notice it may be difficult for families to attend. INQUEST have highlighted a case where a family was informed on Friday 4 December 2015 that misconduct hearings were to take place the following week. The family were unable to attend due to the short notice, and had received no advance warning by the IPCC, even though the IPCC had been aware since 5 November of provisional dates. Families need to be informed in a timely fashion of when misconduct hearings are likely to occur.
- 13.36 At a hearing the family may put questions to witnesses indirectly through, and at the discretion of, the chair of the panel. In theory they can be accompanied by another person, in some cases a solicitor, to guide them through the process but the solicitor has no formal role in proceedings, and may or may not be permitted to take notes.
- 13.37 The Government should consider whether there is a need for a family's role at a misconduct hearing to be clarified, standardised and applied with more consistency. Consideration should also be given to advance disclosure of evidence to family members recognised as interested parties (subject to the harm test, which states that investigators are entitled to withhold information that would otherwise be disclosable if there is a real risk that disclosure would have a 'significant adverse effect' on the proceedings).

Sanctions

- 13.38 There has been some concern raised by supporters and families of the deceased that appropriate sanctions often do not follow where gross misconduct has been demonstrated. Dismissal does not automatically follow. As one family member told this review:

“You hope they will give you the justice you are searching for. The officer found guilty of gross misconduct got a written warning because he was an exemplary officer with 22 years’ service.”

- 13.39 The IPCC has also recognised this in their *Review of the IPCC’s work in investigating death* published in March 2014¹³⁴:

“We share the frustration when there is a clear disconnect between our investigation findings and the outcome of the misconduct hearing that follows. In some instances, although we have determined that an individual has a case to answer for gross misconduct, the panel at the subsequent misconduct hearing concludes that the individual’s conduct amounts to misconduct only, or that it amounts to no misconduct at all.

“In other instances, the panel agrees that the individual’s behaviour amounts to gross misconduct but then goes on to impose a sanction that is more lenient than the IPCC and families would expect and which, in our view, does not reflect the seriousness of the failings identified.”

- 13.40 This all adds to the perception that police forces are more concerned with protecting its officers than properly holding them to account. This perception may be unfair. There should be no ‘one size fits all’ approach, and forces may have valid reasons for employing a more lenient sanction, but these should be in exceptional circumstances only, and the justification properly explained. Otherwise such decisions can only lead to mistrust in the whole process, and a perception that the police are untouchable. INQUEST is aware of only one case where an officer has been dismissed following a death in custody.

134 https://www.ipcc.gov.uk/sites/default/files/Documents/deaths_review/Review_of_the_IPCCs_work_in_investigating_deaths_2014.pdf

Recommendations:

- There should be a duty for police officers to provide a full and candid statement at the earliest opportunity and within the specified timeframe unless they are formal suspects.
- Article 2 related cases should be dealt with in the same time scales as a civilian homicide case and the appropriate resources deployed by all agencies to achieve the completion of the investigation and decision making process within the robust timescale achieved in those cases.
- In Article 2 related deaths the IPCC should consider making a formal written request for the restriction of duties (in misconduct investigations) and the suspension of officers pending the outcome of gross misconduct and/or criminal investigations, although the final decision should remain with the Chief Constable.
- The IPCC should publish criteria for deciding on whether police action amounts to misconduct or gross misconduct.
- The IPCC should be responsible for informing all interested parties as soon as a misconduct hearing is arranged. There must be adequate notice for a family to attend, and their rights should be fully explained.
- The Government should consider whether there is a need for a family's role at a misconduct hearing to be clarified, standardised and applied with more consistency, and advance disclosure of evidence to family members recognised as interested parties (subject to the harm test).
- Once clear criteria have been made open and transparent, dismissal should always follow findings of gross misconduct unless there are wholly exceptional circumstances which justify a different sanction. Such exceptional circumstances must be fully explained to the family.

14. Prosecutions

14. Prosecutions

Introduction

- 14.1 There is a strong perception that families of those who die in police custody are not treated as ‘victims’ in the same way that relatives of murder or manslaughter victims would be, and that the criminal justice system is resistant to and uncomfortable in treating deaths or serious incidents in custody as a potential crime from the outset.
- 14.2 It has been a longstanding complaint of supporters and families of people who have died in police custody that the criminal justice system has not delivered the rigorous and impartial service expected of them. The police are traditionally viewed as protectors of Human Rights and police officers will give evidence regularly in the courts to secure the conviction of those accused of crime. When it is officers of the state itself who may have breached such rights, the circumstances are more shocking for those in the system since it is the very system itself that comes under scrutiny and challenge. While the occurrence of a death in custody may cause great shock and concern within the police force, families feel that very rapidly that shock is replaced with defensiveness.

“While the occurrence of a death in custody may cause great shock and concern within the police force, families feel that very rapidly that shock is replaced with defensiveness.”

- 14.3 This sometimes manifests itself in pejorative press releases by the police about the deceased and early questioning of next-of-kin about the quality of their own parenting or support to the deceased. Families feel they are viewed with suspicion rather than with the compassion shown to other families whose loved ones are considered victims of crimes by non police perpetrators or who have been involved in an accident or disaster.
- 14.4 Given the estrangement from the police that families may feel in such cases the effectiveness of the responses of the IPCC and the Crown Prosecution Service becomes critical to maintaining faith that the State will fulfil both its domestic law obligations and those under Article 2 of the European Convention on Human Rights.

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- 14.5 Of eight prosecutions of police officers in connection with a death in custody in the last 15 years, all have ended with acquittals. These include prosecutions for murder and manslaughter. In fact, there has never been a successful prosecution for manslaughter in this context, despite unlawful killing verdicts in Coroner’s Inquests. This does not prove that the criminal justice system has failed to deliver justice, but it goes to the heart of why families so often feel let down by the system.

Referrals to CPS

- 14.6 Following a death or serious incident in police custody, the CPS is informed in the first instance by the IPCC. The IPCC lead investigator will notify the CPS Special Crime Division of an IPCC investigation within five working days of the mode of investigation decision being taken. This is set out in a Memorandum of Understanding between the two bodies which was updated in 2016.
- 14.7 As a result of this agreement, the CPS believes it is now getting involved in cases much earlier. In very serious or high profile cases the CPS would expect to be notified earlier than five working days. The benefits of early involvement of the CPS cannot be overstated. The prosecutors should be able to advise on evidential considerations and lines of enquiry from the perspective of what is necessary and desirable for presenting a case in court. Failure to liaise with the CPS at the earliest possible stage, and regularly thereafter, risks weakening the investigation or risks wasting time and resources within the IPCC.
- 14.8 The move for the IPCC and CPS to engage more quickly and effectively was a response to external feedback, including pressure from the charity, INQUEST. Over the years INQUEST has highlighted what it sees as shortcomings in the referral of cases to the CPS. In written evidence to this review INQUEST stated:
- “Recent cases had revealed poor understanding of the referral criteria on part of some investigators and Commissioners and failures to review referrals throughout the investigation as evidence emerges.”*
- 14.9 As a result of such feedback, the IPCC now approaches the CPS for advice more often. However, some evidence given to this review suggested that the IPCC might be sensitive about not being seen to compromise their independence by following external advice. The IPCC officers should recognise that independence does not require isolation and it is critical that there is the most effective consultation between these agencies and, where relevant, with the Health and Safety Executive.
- 14.10 INQUEST have recognised that there have been some changes with earlier referrals to the CPS by the IPCC in order to seek input and advice into potential criminal aspects of a case during an investigation, or advice on what experts to consult, rather than waiting for the conclusion of its own investigation, or the formal Inquest. They do however have ongoing concerns about long delays and the quality of decision making.

14.11 For example, the cases of Thomas Orchard, Duncan Tomlin, and Leon Briggs have all been referred to the CPS. The case of Thomas Orchard is particularly significant as following early involvement from the CPS a decision to prosecute for manslaughter and misconduct in public office was taken before the inquest was held. The CPS will usually decide on whether to lay charges before the Inquest takes place. Sometimes however evidence leading to a prosecution may only emerge at the Inquest (if, for example, a witness changed their evidence, or there were flaws in the original investigation).

CPS decision making

14.12 Concerns have been expressed to this review that the component parts of the criminal justice system may have a conscious or unconscious bias against prosecuting police officers. It was suggested that such a bias stems from a culture where officers' accounts are generally perceived as credible and reliable, and exist in the context of thousands of cases where the police are usually the main, and sometimes only, witnesses to what occurred. There is also a concern that decisions by the CPS on whether to prosecute may be unduly influenced by a 'fatalistic' approach. In the context of 100% acquittal of eight prosecutions in 15 years, it may be tempting for decision makers to adopt a pessimistic attitude towards the prospect of a successful prosecution.

14.13 It is of course impossible to know to what degree, if any, these concerns are justified. It may be that there is a general default position in wider society to automatically trust the word of a serving police officer, although such deference to authority may perhaps not be as widespread following such high profile tragedies as the Hillsborough disaster¹³⁵. Certainly CPS decision makers should be properly trained to identify 'unconscious bias'. They must also fully heed the 'merits based approach'¹³⁶ to decision making.

14.14 It should however also be recognised that in any decision to prosecute, the CPS must prove the case against each individual accused beyond reasonable doubt and in their own decision making are bound by a "realistic prospect of conviction" test. According to CPS guidance:

*"Crown Prosecutors must be satisfied that there is enough evidence to provide a "realistic prospect of conviction" against each defendant on each charge. They must consider whether the evidence can be used and is reliable. They must also consider what the defence case may be and how that is likely to affect the prosecution case."*¹³⁷

135 <https://hillsboroughinquests.independent.gov.uk/>

136 http://www.cps.gov.uk/legal/l_to_o/merits_based_approach/index.html

137 <https://www.cps.gov.uk/about/principles.html>

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- 14.15 A “realistic prospect of conviction” means that a jury or a bench of magistrates will be *more likely than not* to convict the defendant of the charge alleged. There are checks and balances within the CPS to ensure that decisions are made on a proper basis. This includes the ability to seek a review of a decision not to prosecute, which is conducted by senior prosecutors not involved in the original decision making.
- 14.16 The CPS must be prepared to review a decision not to bring criminal charges, if new evidence subsequently comes to light. There may be occasions where an Inquest returns a verdict that may give cause for the CPS to reconsider its original decision (for example a verdict of unlawful killing). The CPS needs to be confident that it has a robust internal mechanism to review its decisions where subsequent developments appear at odds with their finding in these difficult cases.

Corporate Manslaughter

- 14.17 Corporate Manslaughter is a statutory offence that was introduced to provide a means of accountability for very serious failings across an organisation. The provision was intended to overcome the problems at common law of identifying any senior individual and of aggregating responsibility to senior management within an incorporated body. The offence now includes liability for organisations that could not previously be prosecuted for manslaughter. It is intended to work in conjunction with other forms of accountability such as gross negligence manslaughter and other health and safety offences. The ability of the CPS to charge Police Forces with Corporate Manslaughter came into effect on 1 September 2011 when the relevant provisions in the Corporate Manslaughter and Corporate Homicide Act 2007 came into force. Since then the CPS has not used this power to charge a force.
- 14.18 The ability to prosecute forces for corporate failings is significant. When individual officers are investigated or prosecuted it is all too easy for them to be dismissed as ‘bad apples’ or the facts as isolated incidents. A Corporate Manslaughter charge, where appropriate, ensures that any systemic failings can be properly addressed and ensure accountability for such failings at the most senior levels.
- 14.19 The Health and Safety Executive (HSE) is responsible for investigating deaths at work places and where working practices may amount to criminal breaches of the duties towards members of the public. The HSE decides whether or not to proceed with health and safety prosecutions (as distinct from corporate manslaughter charges), for charges brought under the Health and Safety at Work Act 1974. The CPS can also consider and prosecute health and safety offences.
- 14.20 Section 1 of the 1974 Act states that the provisions shall have effect with a view to securing the health, safety and welfare of persons at work; but also, to:
- “(b) protecting persons other than persons at work against risks to health or safety arising out of or in connection with the activities of persons at work;”*

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- 14.21 This indicates that under the terms of the Act, there is a wider responsibility to ensure the safety of the wider public – not just people at work – who may be affected by the workplace health and safety failures. Penalties for breaches of the Act can incur unlimited fines and up to two years in prison.¹³⁸
- 14.22 The ‘Work-related Death Protocol’¹³⁹, of which the CPS, HSE and National Police Chiefs’ Council are signatories, sets out the test for whether a corporate manslaughter charge can be laid. The protocol states:

“For corporate manslaughter, there are a number of elements to the offence which need to be proved:

(a) the defendant is a qualifying organisation;

(b) the organisation caused a person’s death;

(c) there was a relevant duty of care owed by the organisation to the deceased; and

(d) there was a gross breach of that duty which fell far below what was reasonably expected of the organisation in the circumstances.

“Additionally, for corporate manslaughter, the conduct (the way in which the company’s activities were managed or organised) of senior management must be a substantial part of the corporate failing. Senior management are those who make decisions about how all or a large part of the company’s conduct is managed or organised.

“In deciding whether there has been a gross breach of duty, the jury must consider whether any health and safety legislation was breached, and if so must consider:

(i) the seriousness of the breach; and

(ii) how much of a risk of death it posed.”

- 14.23 As the protocol itself acknowledges, this is a very high bar to bringing such prosecutions. Nevertheless the ‘merits based approach’ should be adhered to at all times, and proper consideration should be given to a corporate manslaughter charge at the outset. There is also a pressing need for the IPCC to consider more fully the potential for HSE charges in the context of these cases, and for much greater involvement of the HSE during IPCC investigations to ensure that due weight and expertise is being given to the possibility of potential health and safety charges in deaths occurring in police custody.

138 <http://www.hse.gov.uk/enforce/enforcementguide/court/sentencing-penalties.htm>

139 <http://www.hse.gov.uk/enforce/wrdp/>

Delays in CPS decision making

- 14.24 A common theme running through the evidence to this review has been the grave concern about delays in both the investigation and decision making on prosecution. Concerns were expressed about the police sometimes taking too long to notify the IPCC of a death, of delays in the attendance of the IPCC at the scene of the death, about the length of the IPCC investigations that ensue and the time taken to bring an inquest to its conclusion. As a consequence of some or all of these factors deaths and serious incidents in police custody can take years to resolve. This is unacceptable. For the families of the deceased it prolongs their suffering and grief. Police officers too may find themselves in limbo, on restricted duties, or suspended from their jobs (although this is less common than being on restricted duties) and suffering tremendous stress. It is clearly in the interests of all parties and the public interest that the process is completed as efficiently and effectively as possible. This process has been further exacerbated by sometimes very lengthy periods before the CPS make a decision about the case.
- 14.25 In written evidence to this review INQUEST gave the example of the death of Colin Holt:
“... in the case of Colin Holt the death occurred in August 2010 and the IPCC investigation was conducted as a potential criminal investigation from December 2010 on but a decision to charge was not made until September 2012 and the trial took place in May 2013. The trial judge commented negatively on how long the trial process had taken, as this stood out as compared to other cases before the Crown Court.”
- 14.26 It may also be the case that the IPCC has taken a long time before referring a case to the CPS, as in the case of Thomas Orchard where the death occurred in October 2012 and the case was referred to the CPS in July 2013. It took almost another year and a half before the CPS took a decision to charge, and the trial did not start until January 2016 (a new trial is scheduled for January 2017 after the Judge ordered a retrial). In written evidence to this review the CPS stated that:
“It is acknowledged that investigations into deaths in custody can – given their complexity - take a long time to reach an outcome, and are occasionally subject to unjustified delays. We have reviewed our working relationship with the IPCC to ensure that it is underpinned by the principles of early engagement, closer collaboration, and effective case progression. Our memorandum of understanding with the IPCC has recently been revised to that effect, and we believe that this has already begun to minimise delays in case progression.
“In some cases, especially those in which it appears a police force may have been criminally responsible for a death, it can be especially difficult for investigators to obtain timely, credible evidence from the force under investigation. Whilst this is an inevitable challenge with investigations of this type, we will continue to support our partners at the IPCC as needed to help deliver full, fair investigations.”

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- 14.27 The issue of the CPS obtaining ‘timely, credible evidence from the force under investigation’ is critical. There should be an explicit duty of candour on the police to cooperate fully with all investigations into allegations against its officers. Individual police officers under suspicion of an offence have a right to silence, but if others are witnesses to the failing they have a duty to cooperate.
- 14.28 Similarly, police forces must fully cooperate with investigations. In the event of a prosecution against a police force its own employees can be used as witnesses against that force, and would therefore have a duty to cooperate.
- 14.29 Delays may be caused by a lack of early engagement with the CPS during the course of the IPCC investigation. This is acknowledged by both organisations who have now put measures in place to encourage early and regular communications:
- “Contact between the IPCC and CPS can take place at any time during an investigation and for a number of different reasons. The nature and method of contact can vary depending on the individuals involved in the case and the requirements of the investigation.*
- “A recently revised Memorandum of Understanding (MOU) between the IPCC and CPS has sought to regulate some of this contact, to ensure that frequent, scheduled updates are provided between both parties.”¹⁴⁰*
- 14.30 The CPS needs to be properly resourced to consider potential criminal activity by police officers. The most serious cases involving death are a matter of major public interest and deeply distressing for families of the deceased. Any unnecessary delays in such grave cases are unacceptable. It is also in the interests of police officers under investigation that they too benefit from timely decisions.

Expert evidence

- 14.31 Decisions on whether or not to lay criminal charges following a death or serious incident in police custody may be informed by the use of expert evidence. Both the IPCC and CPS need to be able to take informed decisions based on the best available evidence at the time, and be prepared to review those decisions if new evidence later emerges.
- 14.32 The charity INQUEST has highlighted to this review examples of where they believe the CPS fell short in this regard:
- “Following the shooting of **Azelle Rodney** a decision in 2006 not to prosecute the shooter officer was based upon the CPS taking that officer’s account at face value. It was accepted that he had an honest belief in the need for lethal force without testing his account against the scientific evidence...After a public inquiry was established in 2010 the inquiry team, which included counsel and solicitor to the inquiry, conducted their own analysis of the evidence. This, together with new scientific*

¹⁴⁰ An analysis of the working arrangements between the IPCC and CPS during death in custody investigations: A joint IPCC and CPS report, May 2016

and reconstruction evidence, significantly undermined the officer's account...All of this material taken together enabled findings that led the inquiry Chairman, Sir Christopher Holland, to dismiss the officer's account that Azelle Rodney had picked up a weapon and was about to use it and to conclude that Azelle Rodney was unlawfully killed. A second CPS decision followed and a prosecution was brought based upon the evidence that was before the public inquiry.

*"Following the death of **Christopher Alder** in 1998 the CPS decided that a prosecution would be brought for misconduct in public office but not for manslaughter. After the jury returned an unlawful killing verdict at the inquest the CPS maintained their position, claiming that the expert evidence as to the cause of death was too ambiguous (despite the jury's verdict which requires the criminal standard "beyond reasonable doubt"). It was only after the family obtained a further expert report (additional to those reports obtained for the inquest) that the CPS changed their view and agreed to add a manslaughter charge."*

- 14.33 In the case of Azelle Rodney, a police officer was acquitted of murder by majority verdict at trial in June 2015. In the case of Christopher Alder five police officers were charged with manslaughter, but the trial collapsed in 2002. The fact that expert evidence allowed the CPS to review its decision to bring charges, demonstrates the value of commissioning independent expert evidence as soon as possible. All due consideration should be given to this by the CPS in its future casework.

CPS communication with families

- 14.34 Where there are delays, inevitably it is the families of the deceased that suffer the most. Police Officers subject to investigation are also placed under enormous strain. Some families have been kept in limbo for years awaiting decisions from the CPS about potential criminal charges. This means that the CPS must have in place robust processes to keep families informed at all stages of the process. In written evidence to this review the CPS stated:

"The CPS has clear systems in place to ensure that the family are at the very least kept fully informed at every stage. In cases of deaths in custody, as in any case involving a bereavement, we recognise the importance of keeping victims (which includes the families of the deceased) fully informed. The CPS, together with its partners across the criminal justice system, is committed to upholding the 'Code of Practice for Victims of Crime'. The Code sets out the service that victims of crime are entitled to receive. Bereaved close relatives have enhanced entitlements, which include an opportunity to meet with the CPS prosecutor handling the case at various stages of the investigation. If the CPS prosecutor, having considered the evidential and public interest factors involved, decides that a prosecution should not be brought, the reasons for this will be clearly explained to the family, usually in person. Such a decision can be challenged by the family under the CPS's Victim's Right to Review Scheme."

14.35 Whilst these commitments are welcome, the CPS must carefully monitor its own adherence to its systems and to the Code of Practice for Victims of Crime. In evidence given to this review one family member stated:

“It is a joke how CPS, IPCC and HSE all blame each other about the delay, no one takes the responsibility, it was on someone’s desk for three months, this prolonging has been agonising for family, they have no idea of this.”

14.36 These cases should be afforded the upmost priority and, as mentioned above, the CPS needs to consider whether it has adequate, senior resources (compared to, say, the resources for a homicide investigation) to enable full, timely and meaningful communication with families, and indeed to progress the decision-making process in a timely fashion. The CPS need to be clear when there are delays about the reasons for this, and what action they are taking to put things right.

Health and Safety Executive and the CPS

14.37 Health and safety prosecutions in the context of a death at the hands of the state have, on occasion, been employed as an alternative to homicide charges in police shooting cases, most notably in the deaths of Jean Charles De Menezes and Anthony Grainger. Both these prosecutions were brought by the CPS, not the HSE, with the CPS deciding that there was insufficient evidence to support a homicide charge. Some interest groups expressed concern however that health and safety prosecutions might be used as a convenient alternative to more serious criminal charges.

14.38 Health and safety charges have often arisen in high profile cases where there is much media attention – often in cases involving the use of force and restraint. Such prosecutions should not be limited solely to contentious high profile cases. Given that the focus of a health and safety prosecution is on management systems, other kinds of deaths in custody involving wider management failings might benefit from such prosecutions.

14.39 Deaths resulting from systemic failures to routinely implement standard processes (for example observation regimes) within the police station might fall into this category. If knowledge of such failings were not acted on by management, there could be a clear basis for a health and safety prosecution.

14.40 Where there is a clear health and safety aspect to a death or serious incident, and where multiple agencies are involved in an investigation, it is crucial that they work closely together from the outset.

14.41 Guidance published by the HSE¹⁴¹ states:

“The IPCC (Procurator Fiscal in Scotland) would lead on death or serious injury to detainees in Police custody and may involve HSE under the Work-related Death Protocol (WRDP).

“Death or serious injury to a hospital patient during or following the use of police restraint is always subject to investigation by the IPCC of the conduct of the officers involved. The IPCC will take the lead in these cases but should work with HSE in accordance with the IPCC/HSE agreement and WRDP principles. HSE will investigate the role of the police force, the role of the healthcare organisation and any health and safety management failings by either party.

“These situations are generally very unpredictable and volatile. Such unpredictability may influence the tactics deployed and there may be issues of self-defence for the police officers and hospital staff involved. All of these factors will introduce a greater complexity into the investigations.”

14.42 The Work-related Death Protocol enables the IPCC to bring the HSE into any investigation where there are suspected health and safety failings. However, the IPCC have primacy over the investigation and are not obliged to do so, and according to evidence given to this review by the CPS the HSE is not usually considered if the scene of death is a police cell.

14.43 Clearly there is a need for the separate responsibilities of the HSE and CPS to be set out in this way, but there is also an obvious need for close collaboration between these bodies and the IPCC at the early stages of the investigation. In its submission to the review INQUEST highlighted a specific case where a failure to properly coordinate has resulted in delays and confusion:

“An example of a frustrating process involving multiple agencies is the case of Olaseni Lewis, who died in 2010 following prolonged restraint by police officers whilst in psychiatric detention in an NHS Trust hospital. In addition to the IPCC investigation into the actions of the officers involved in the fatal restraint the HSE conducted an investigation into the NHS Trust. The HSE did not extend its investigation to the police force because of the IPCC investigation. In 2015 it emerged that since 2012 the HSE had been in communication with the MPS, IPCC and CPS regarding corporate manslaughter by the NHS Trust, without any single agency taking responsibility for that matter. Later that year Devon and Cornwall Police began to undertake such an investigation. In the meantime the IPCC referred their investigation to the CPS in relation to the actions of individual officers, but not the MPS as a corporate body. The inquest has now been scheduled to commence in January 2017, over six years on from the death.”

141 <http://www.hse.gov.uk/enforce/hswact/docs/situational-examples.pdf>

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- 14.44 In order to progress investigations in a timely manner, and ensure that all agencies are working efficiently and effectively, it is critical for the IPCC, CPS and HSE to meet early following a death in police custody to review the emerging evidence, and to take an early view as to whether criminal charges including health and safety charges or corporate manslaughter might be a possibility, allowing each agency to consider and plan their own position and provide observations or expertise to the IPCC, and to set a timetable, which should be submitted to the Coroner. Such a meeting should be led by the IPCC and take place within 14 days of an incident with further regular meetings throughout the process as more evidence comes to light and the investigation progresses.
- 14.45 Such meetings should be put on a formal basis, through a Memorandum of Understanding developed by all parties, and reviewed after two years to assess the effectiveness of the process.

Recommendations:

- There should be a formal meeting between the CPS, HSE, and IPCC within 14 days of a death or serious incident. This meeting should be chaired by the IPCC to discuss the emerging evidence, the probability and/or possibility of criminal charges and the nature of these charges, and be a precursor to regular cooperation and advice between these bodies for the duration of the investigation. The meeting should set a timetable to be submitted to the Coroner. The liaison should be formalised through a Memorandum of Understanding.
- In cases where the IPCC and HSE are actively involved, Coroners should hold prompt and regular pre-Inquest hearings requiring the agencies to liaise closely and account for the progress of their work and coordination.
- The CPS specialist unit handling prosecution decisions about deaths in police custody should be reviewed to ensure it is properly resourced with experienced prosecutors for consideration of such serious cases.
- There should be an explicit duty of candour on the police to cooperate fully with all investigations into allegations against its officers.

15. Family Support

15. Family Support

Introduction

- 15.1 During the course of the review I found the dignity and tenacity of the many families of those who have died in police custody humbling. In many cases, with little support, resources or expertise, they have over many years had to make themselves experts in police procedures and practices as well as case law because of the need to attend meetings with investigators and hearings before the courts. They have asked pertinent and probing questions and maintained pressure on the authorities despite the personal and financial toll of their determination. Many have struggled over many years to have decisions overturned and some continue to struggle.
- 15.2 The involvement of families in the process should not be seen as a matter of being sympathetic or benevolent to bereaved relatives. It is the duty of the state to ensure their participation is meaningful. In order to facilitate such participation, families need free legal advice, assistance and representation from the earliest point following the death – and this should be non-means tested for all the reasons set out in Chapter 16. Under Article 2 of the *European Convention on Human Rights* families of the deceased must be allowed to be involved in the investigation. This was confirmed by the European Court of Human Rights in 2001 in its ruling on *Jordan v UK* which stated:

“In all cases, however, the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests.”¹⁴²

“The involvement of families in the process should not be seen as a matter of being sympathetic or benevolent to bereaved relatives. It is the duty of the state to ensure their participation is meaningful.”

142 <http://hudoc.echr.coe.int/webservices/content/pdf/001-59450?TID=scwcmaacah>

- 15.3 This was later upheld by the House of Lords in its 2003 ruling on *Regina v. Secretary of State for the Home Department (Respondent) ex parte Amin (FC) (Appellant)*.¹⁴³
- 15.4 Many bereaved families have very poor experiences of post-death procedures at a time of great trauma and vulnerability and in circumstances that are outwith their previous experiences. During the review a common theme emerging from the evidence of families of those who have died in custody was of a failure to recognise the families as vulnerable or as “victims” within the legal processes that follow the death, in the same way that relatives of, for example, a murder victim or someone killed in a road traffic incident or disaster would be treated.
- 15.5 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. This was illustrated in the cases of Azelle Rodney and Thomas Orchard. In written evidence to this review the charity INQUEST observed:
- “Families also do not receive practical support as do those who are recognised as ‘victims’ within the criminal justice system. It is notable that as soon as police officers were charged with criminal offences the families of Azelle Rodney and Thomas Orchard were assisted by Victim Support with transportation and accommodation around the trial. This is in sharp contrast to how families in death in custody cases are generally treated.”*
- 15.6 What compounds the lack of official support for families is their having to deal with new and traumatic procedures at a time of grief and uncertainty. There is no standard way in which families are helped, and often they must navigate the process alone. The experience of families who spoke to this review was that the earlier they received independent support and advice, the more worthwhile was their engagement with the investigation and subsequent inquest process. INQUEST can play a valuable role here in helping families through the process due to the wealth of experience it has accumulated over the years, but in many cases families only find out about the Charity by accident, often when conducting an internet search for information about Inquests.

“What compounds the lack of official support for families is their having to deal with new and traumatic procedures at a time of grief and uncertainty.”

143 2003 UKHL 51

Access to information and advice

- 15.7 When an individual is arrested and taken into custody certain legal rights, including the right of access to legal advice, flow from that status. The most serious prospect that could ever arise for an arrestee from the fact of being arrested is death and yet, paradoxically, that event does not trigger the provision of immediate access for next-of-kin of the deceased to legal advice. The immediate aftermath of a death in custody is the point of the process, more than any other, when families are in urgent need of advice, support and information about their rights, and the processes that will ensue over the coming days and months.
- 15.8 Unfortunately, it is also the point at which families will be in a state of shock, confusion and grief. Their ability to absorb information, and understand what is happening may be affected as a result. The many families who spoke to this review advised that early independent support and advice is crucial to their engagement with the process, and yet, in their experience, is rarely forthcoming.
- “The IPCC didn’t give us any information whatsoever about what had happened. They didn’t give us any information about what would happen. There was no support, no transport.”*
- “A counsellor told us about INQUEST but it was too late for us. Twenty six (26) months down the line we’d had no advice and support.”*
- “I asked the police ‘do I need to get a solicitor’ and they said ‘it’s up to you, most families don’t’.”*
- “Every night, seven nights a week after coming home from work and I had nobody to bounce it off. I was looking on Google because I didn’t understand what things meant. I was very ill equipped for the process, so out of my depth.”*
- 15.9 The sense of frustration and anger at being left completely out of the picture in the first days and weeks of the investigation was evident from the many families I met during the review. All agencies need to look urgently individually and collectively at their internal processes for disseminating information to bereaved families in these cases. Not only does information need to be timely, but it must be delivered sensitively, with empathy, and an understanding that information might not be taken in the first time by families trying to cope with grief and shock. Families do not want to be patronised but to be given the earliest possible notification of the death and immediate specialist advice about how they can secure independent advice for themselves.

Information released to the public

- 15.10 There is a perception among families and those who subsequently advise them that following the death police forces have been quick to portray the deceased, and their friends and relatives in a poor light in an effort to neutralise any public sympathy. Families cite examples of the police and IPCC questioning them about the lifestyle of the deceased, and incorrect details, false narratives and ‘victim blaming’ about their loved ones appearing almost immediately following the death in press reports, of which the family had no prior notice, and no ability to correct.

“They said information was given that (relative) was a drug addict, but that’s not true, she had mental health problems. There was an article in the press saying she was a drug addict and the reporter said the information was from the IPCC.”

- 15.11 This was seen by the families of the deceased as being part of a culture of defensiveness from the very beginning, where no one wanted to acknowledge a possible mistake and aim to put things right.

“They are trying to criminalise your loved one, trying to paint you as being a bad character. They’re trying to discourage you by painting a case that is never against the police, but is against you. No one wants to say ‘we are wrong’. If that happened then families would be satisfied as accidents do happen.”

- 15.12 When people die in police custody there is invariably media interest. This can result in the police and IPCC being bombarded with requests for statements. Given this media pressure it may be understandable for those bodies to want to make timely public statements, given the way that rumours can, and do spread when there is an information vacuum. However, factually incorrect or misleading information should never appear in the public domain.

- 15.13 The release of inaccurate or unfavourable information about the deceased to the media is perceived by families as a pre-emptive strike designed to create prejudice against the deceased and thereby exculpate any police officers in the minds of members of the public even before the IPCC have taken over the investigation. A rush to release information could result in the media being made aware of the death before the family have been informed. Since its Article 2 review the IPCC have made efforts to involve families in the issue of press releases. Such good practice is inconsistent with a rush to release information. Unless there are exceptional circumstances which require the urgent release of information, the police should not issue any information to the media, but should leave this to the IPCC. It is vital for the IPCC to ensure they are nimble in responding to the demands of the media while ensuring that the family are engaged in this process.

“The release of inaccurate or unfavourable information about the deceased to the media is perceived by families as a pre-emptive strike designed to create prejudice against the deceased.”

Attending inquests

- 15.14 Families who attend Inquests must do so at their own expense. This often requires having to take time off work – and a subsequent loss of wages – as well as potential travel and accommodation costs. For a contentious hearing which may last several weeks the financial burden could be crippling. Often, families have little choice but to attend only for a day or two of proceedings. Under current provisions witnesses and jurors will be appropriately compensated, but these provisions are not available to families.
- 15.15 The Government therefore needs to consider the feasibility of a scheme to pay reasonable travel and subsistence and compensation for loss of earnings for immediate family to attend the inquest in those inquests relating to deaths in police custody.

Counselling and support services

- 15.16 The trauma that some families suffer in the wake of a death is exacerbated by the lengthy process that often follows. It is simply not possible for families to begin the grieving process or achieve closure when, in some cases, they may wait years for a resolution. Even when that resolution comes, some families have been compelled to continue campaigning. Cases where the IPCC have been obliged to reopen investigations as a direct result of family campaigning or a recognition of a flawed investigation demonstrate that the official closure of an investigation does not always mean closure for families. As INQUEST stated in written evidence to this review:

“The families with whom INQUEST works report high levels of emotional trauma during a lengthy bereavement process...It is subject to protracted and intrusive post death processes. Many report severe difficulty in day to day functioning, including suicidal thoughts and difficulty experienced by bereaved children. The investigation and inquest process is lengthy so that several years is not unusual and in some cases

legal proceedings continue for periods as long as six years plus. Many people find that the grieving process is slow or cannot really begin until after the inquest is over.”

- 15.17 Trauma can manifest itself in many ways. Families spoke movingly to this review about the emotional suffering they have had to endure:

“Losing a child is very difficult as parents. He had mental health issues which took up a lot of emotional time and energy. For the last five to six years it feels like we are looking after him while he is dead. I feel numb and sad. I won’t really grieve properly until this process is finished. It is inhumane for the process to be 8 or 9 years. Why not do it in 18 months?”

“Over five or six years, all the meetings we’ve had, three investigations, met the Home Secretary three times, can’t imagine how many days I’ve had to take off work. A day or two before hand I can’t sleep and I can’t eat. I have to psych myself up and afterwards I’m completely exhausted the next day. It takes me three days to get over it. Then the trauma of remembering everything.”

“It’s coming up to five and a half years. The toll, the strain, arguments, if I don’t have a reason, I don’t get out of bed.”

- 15.18 Access to counselling and other forms of support is therefore hugely important, yet, according to INQUEST, it remains ‘patchy’ and varies according to the availability of local resources. Families who spoke to this review felt there was a ‘deficit of support’ available and that ‘in order to access services families are confronted by perceptions of stigma and judgement, and there remain serious questions about the inconsistent provision of support services’¹⁴⁴.

- 15.19 Some of the families had used counselling services, and for some it had ‘helped a great deal’:

“Without the counselling I’d be a bit of mess. I’m always 5 minutes away from ranting.”

“I was lucky enough to get counselling. I was sceptical at first. The inquest is so exhausting, the only way to move forward is to find a balance and counselling is a way to get a plan, a method of dealing with it.”

- 15.20 Often families will have to pay for the cost of counselling themselves – an obvious deterrent for seeking potentially vital support. There is a need therefore for properly funded specialist bereavement counselling which can be offered to families from the outset similar to that offered by the Homicide Service of Victim Support¹⁴⁵. For some families it may be too soon to want to speak about their experiences, but the offer of counselling should be on the table for the duration of the various investigations, and indeed well after their conclusions.

144 See Annex D

145 <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service>

The INQUEST Charitable Trust

15.21 INQUEST was set up in 1981 and is the only organisation that supports bereaved families to navigate the complex investigation and legal process after deaths in custody and detention. Casework informs its policy work to improve the treatment of bereaved people, more effective investigations and achieve systemic and legislative change to prevent future deaths.

15.22 The families who gave evidence to this review spoke very highly of INQUEST and the service they offer. One of the main advantages for families who were being helped by INQUEST was their ability to meet with others who were experiencing the same thing. The chance for families to share their experiences, and realise that they are not alone, can be of immense value in dealing with the grieving process.

“I met other family members at meetings in London. This was very helpful. Their experiences being similar, they have understanding of what is happening inside you. I met some of the bravest and most dignified people ever.”¹⁴⁶

15.23 However, it is clear from those who spoke to this review that families were often not told about the work of INQUEST by state agencies, and would often find out about it later in the process. Some relatives reported that they only found out about INQUEST by chance.

Families as a source of learning

15.24 It became clear during the review that one of the main factors that motivates families is a desire that no one else in future should have to endure what their loved one or they have experienced. As the former Home Secretary said in her speech of July 2015:

“I have been struck by the pain and suffering of families still looking for answers, who have encountered not compassion and redress from the authorities, but what they feel as evasiveness and obstruction.”

15.25 It is for this reason that the accumulated knowledge and experience of families should be harnessed by the various agencies of the state, who should consider how best to involve them in training and awareness exercises. The value of family interaction was illustrated by the IPCC in written evidence to this review:

“INQUEST facilitated a family listening day. The advice provided by families was very valuable and as a result we identified several actions to try to improve the experience of families. This has included providing training on bereavement awareness to all IPCC investigators and commissioners, and re-writing the information that families first receive from us.”

¹⁴⁶ Unlocking the Truth: Families' Experiences of the Investigation of Deaths in Custody, Helen Shaw & Deborah Coles, 2007

Recommendations:

- In order to facilitate their effective participation in the whole process there should be access for the immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the pre inquest hearings and Inquest hearing.
- Before the IPCC has formally taken over an investigation the police should make no public comment on the matter. Unless there are exceptional circumstances which require the urgent release of information the police should not issue any information to the media, but should leave this to the IPCC.
- Any information released to the media should be limited to very basic information about the deceased and the whereabouts of the death, and where possible, agreed in advance with the family, unless there are exceptional circumstances (for example, a witness appeal) where time does not allow for this.
- Police forces, the IPCC, CPS, Coroners offices and the College of Policing should give consideration to how family experiences can be brought into training and awareness packages. As a result of the tragic experience of the loss of a loved one in police custody many next-of-kin have become experts on a range of issues following a death in police custody and exposing officers to these families and listening to them is an invaluable training resource for all levels of command.
- The Government should consider the feasibility of a scheme to pay reasonable travel and subsistence and compensation for loss of earnings for immediate family to attend the inquest in those inquests relating to deaths in police custody. Such a measure is necessary to ensure that access to the inquest hearing is a practical reality in every case. The Government should look at existing models, for example the support offered through Victim Support, when considering such a scheme.
- The Government should ensure that families have funded access to appropriate bereavement services offering specialist counselling to families of the deceased. Those providing the services should understand the impact of a traumatic bereavement involving a protracted, intrusive investigation.
- All state agencies who are engaged with the family, including police, IPCC, CPS and Coroners and their staff should provide both oral and written information about support services, including INQUEST, to families as early as possible when contact is established following the death. Agencies should not assume that this has already been done by others.

16. The Colonial System

16. The Coronial System

Introduction

“It is in the general interests of the community that any sudden, unnatural or unexplained deaths should be investigated and, to reflect this, the role of the Coroner has adapted over the eight centuries since the office was formally established in 1194, from being a form of medieval tax gatherer to an independent judicial officer charged with the investigation of sudden, violent or unnatural death” – Coroners’ Society of England and Wales

- 16.1 Ministry of Justice guidance defines a Coroner as an ‘independent judicial office holder, appointed by a local council’. The Coroner takes lawful control of the body of the deceased in deaths reported to them, orders post-mortem examinations, instructs relevant experts and considers all relevant available evidence in public at the Inquest.
- 16.2 There is no formal national body that regulates Coroners in England and Wales. In an effort to address this, the role of Chief Coroner was created by the Coroners and Justice Act 2009, to provide national leadership for Coroners in England and Wales. The Chief Coroner’s main responsibilities include providing support, training and guidance for Coroners, with the Lord Chancellor approving the appointment of Coroners by Local Authorities, monitoring delays in completing inquests, overseeing transfer of cases between Coroners and promoting greater consistency of approach across Coroner areas, while sensitive to the judicial independence of the office holder . The Chief Coroner produces an Annual Report and publishes Coroners’ Reports with the intention of preventing other deaths. This role has not created a de facto national Coroner Service however, as will be discussed later in this chapter.
- 16.3 The need for an independent investigation where there has been a sudden or unexplained death is enshrined in English law by the Coroners and Justice Act 2009; the Coroners (Investigations) Regulations 2013; and the Coroners (Inquests) Rules 2013. Inquests are usually held without a jury¹⁴⁷, but the 2009 Act states that a jury should be used if the deceased “died while in custody or otherwise in state detention” and the cause of death was violent, unnatural or unknown; the death resulted from the act or omission of a police officer; or the death was caused by a notifiable accident, poisoning or disease.¹⁴⁸

147 35,473 inquests held in 2015 of which 457 were with a jury: source MoJ Coroner Statistics <https://www.gov.uk/government/statistics/coroners-statistics-2015>

148 <http://www.legislation.gov.uk/ukpga/2009/25/part/1/chapter/1/crossheading/inquests>

- 16.4 In addition, Article 2 of the European Convention on Human Rights imposes a procedural obligation on the UK to conduct an effective, impartial, independent and prompt investigation into deaths for which the State might be responsible. The investigative duty arises where there is evidence to suggest the State may be responsible for the death, and also arises automatically (i.e. without the need for such evidence) in certain circumstances, including situations where the State owed a duty to take reasonable steps to protect the person’s life because the person was under the State’s control or care, or where the person was killed by an agent of the State. The investigative duty can also arise where a person has died while detained by the State, or has attempted suicide while detained and sustained serious injury (or potentially serious injury).
- 16.5 According to Government guidance, an investigation conducted for the purposes of Article 2 should open up the circumstances, correct mistakes, identify good practice and learn lessons for the future so as to prevent recurrence of similar incidents.¹⁴⁹
- 16.6 To satisfy this procedural obligation, the State must initiate an investigation that is reasonably prompt, effective, carried out by a person who is independent of those implicated, provides a sufficient element of public scrutiny and involves the next-of-kin to an appropriate extent. This function is provided by the Coroner in England and Wales.
- 16.7 Ministry of Justice guidance states:
- “Coroners usually have a legal background but will also be familiar with medical terminology. Coroners investigate deaths that have been reported to them if it appears that:*
- the death was violent or unnatural*
the cause of death is unknown, or
the person died in prison, police custody, or another type of state detention.
- “In these cases Coroners must investigate to find out, for the benefit of bereaved people and for official records, who has died and how, when, and where they died.”¹⁵⁰*
- 16.8 It should also be noted however that the traditional purpose of an Inquest (who has died and how, when, and where they died) has been supplemented in Article 2 cases by a requirement to investigate *in what circumstances* someone died¹⁵¹.
- 16.9 Coroners should be notified promptly of a death in police custody by the police. At that point the Coroner determines and makes arrangements for a post-mortem examination. The Coroner can also check that the police have notified the Professional Standards Department and the Independent Police Complaints Commission (IPCC), but they have no power to impel them to do so.

149 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474020/Article_2_advice_acc.pdf

150 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283937/coroner-investigations-a-short-guide.pdf

151 *R(Amin) v Secretary of State for the Home Department*, House of Lords, 16 October 2003

- 16.10 The Coroner also has to be mindful of parallel investigations conducted by the IPCC, and potentially the Health and Safety Executive (HSE), the NHS and the potential interest of the Crown Prosecution Service (CPS). The Coroner may typically have to wait for a year for the IPCC to report, and will usually be unable to conclude his or her work until then. In practice the Coroner relies heavily on the IPCC to carry out the investigation, as the final IPCC report will often form the backbone of evidence at the Inquest.
- 16.11 Some Coroners who spoke to this review felt that it would be better for the Coroner to conduct their own investigation and not wait for the IPCC to report. They all felt however that Coroners currently lack the resources and the investigative personnel that would enable them to do so. They also lack the ability to direct external bodies (for example the CPS and IPCC) to follow certain leads of enquiry and seek evidence from specific experts.
- 16.12 Coroners are wholly dependent on Local Authorities for their resources, and in the absence of a National Coroner Service, there is no uniformity or consistency in the way in which the Coroner is resourced or supported. Most Coroners' offices are staffed by police officers seconded from the local force as investigating officers, as well as former or seconded civilian employees of the local force. Some Coroners feel this is necessary as they should have access to non-local authority staff, as there may be occasions where the local authority itself is involved in a death and needs to be investigated. Nevertheless, the use of police staff to support the work of Coroners does nothing to assure families of those who have died in police custody of the independence of the processes leading up to the Inquest hearing.
- 16.13 Coroners who spoke to this review also felt that there was a constant pressure on them to make savings. This made it difficult, for example, to secure the use of experts to provide evidence and expert opinion, as some local authorities would query the need for such additional evidence in an effort to save money. Such behaviour could be a clear interference in the work of judicial officers.
- 16.14 The overall picture from a number of those who participated in the review meetings and focus groups is one of a coronial system under great pressure of resources and that is 'ad hoc', largely dependent on a 'grace and favour' relationship with other agencies (some Coroners report even relying on other agencies to help with photocopying for disclosure at inquests). Participants described Coroners carrying out investigations with no power to direct external bodies and an inconsistent approach by individual Coroners to the other agencies. Some Coroners may also be inexperienced in such grave cases, given the comparative rarity of Article 2 police related deaths in any given jurisdiction.
- 16.15 The dependency of the Coroner on the timeliness and quality of the IPCC investigations in order to satisfy the Coroner's legal obligations creates a real vulnerability in this context for Coroners whose investigative role is largely reactive to the adequacy and outcome of the investigations of others. Indeed the Coroner has the power to suspend his own investigation if another investigation is being conducted by the IPCC or HSE.

Once the inquest hearing commences, the Coroner is in a better position to test and probe the evidence. It is incumbent on Coroners, however, to ensure that their own investigations are reasonably prompt. Again, while Coroners can hold pre-inquest hearings to gauge the state of readiness of participants in the Inquest, they have no power to secure deadlines from those agencies to accelerate their processes. In the event of a decision to charge or prosecute arising from the circumstances of the death the Coroner will suspend the Coroner's investigation.

- 16.16 As discussed in Chapter 14, apart from the Coroner, there may be a number of state agencies carrying out parallel investigations or with an interest in the outcome of the investigation following a death in police custody. In order to ensure that the various agencies are coordinating their work and avoiding gaps or duplication of enquiry or knowledge, a meeting of senior representatives of those other investigative and prosecuting agencies with an interest in the outcome of the IPCC investigations should be held within 14 days of the death to discuss the early emerging evidence, its implications for each and to set a timetable. The meeting should be chaired by the IPCC. This timetable should be submitted to the Coroner. Consideration should be given to the creation of statutory time limits for the agencies. These time limits should be set by the Coroner following a report from the agencies' meeting. A pre inquest hearing should be set before the expiry of that time limit or on cause shown in the event of a significant reason why the time limit should be extended.

Post-mortem Examinations

- 16.17 As soon as the Coroner is made aware of a death he or she assumes jurisdiction over the body. The Coroners (Investigations) Regulations 2013 state that the next-of-kin, and other interested persons, should be informed of the date, time and location of the post-mortem examination. In addition the regulations state that families are entitled to be represented at a post-mortem examination by a medical practitioner.¹⁵²
- 16.18 However, this does not always happen. In the experience of INQUEST and lawyers who have spoken to this review it is exceedingly rare for families to have their own medical practitioner at the first post-mortem examination, which usually takes place very quickly after the death.
- 16.19 It is the responsibility of the Coroner to ensure that the next-of-kin can exercise this right, but it should be noted that the regulations state that *"a Coroner need not give such notification, where it is impracticable or where to do so would cause the post-mortem examination to be unreasonably delayed."*
- 16.20 A grieving family may simply not be in a position to make quick, informed decisions about the best way to engage with post-mortems. Some families who spoke to this review explained that immediately following the death they did not have a full

¹⁵² <http://www.legislation.gov.uk/ukxi/2013/1629/part/3/made>

appreciation of the importance of a post-mortem, or were not informed of their right to be represented. Some families were only informed of a death after the post-mortem had taken place, and others who were informed of the death were unaware that the post-mortem was taking place.

“(They) did the post-mortem before we identified the body. We had to wait 24 hours before they even let us see the body.”

“We were not told about the first post-mortem. They took his brain for investigation. Miscommunication led to a two week delay. We were not told about the second post-mortem and the Coroner’s officer didn’t know either.”

“Some families were only informed of a death after the post-mortem had taken place.”

- 16.21 Such circumstances illustrate a clear need for access to expert legal advice for immediate family from the very earliest stages of the investigation of the death.
- 16.22 There may be occasions when families ask for a second, ‘independent’ post-mortem, and these requests are usually granted. The Ministry of Justice *Guide to Coroner Services* states that *“If you remain concerned about the cause of death, you can arrange for a separate, additional post-mortem examination.”* It should be noted however that the right to a second post-mortem is not explicitly referenced in the 2009 Act, or supporting 2013 regulations, and is effectively at the discretion of the Coroner.
- 16.23 This review has also heard expert advice from a forensic pathologist who was of the opinion that a second post-mortem was not ideal as there would inevitably be a loss of integrity due to injuries sustained during the first post-mortem. He considered that the ideal scenario would be for a joint autopsy (involving both the Home Office pathologist and family pathologist) at the outset, but failing that, a video of the first post-mortem could be an option. The nature of the history given by the police or IPCC to the pathologist may be of considerable evidential significance. It is therefore considered by specialist lawyers that both video and audio recording should be made. Strict measures of control and access to the recording would need to be established.
- 16.24 Ideally the first post-mortem examination should be sufficient, and a second one not required. To achieve this, the post-mortem needs to be open and transparent with a well-understood process where the families would be encouraged to have their own expert representative present. This examination is a critical part of the investigation. Urgent consideration should be made to both video and audio recording of post-mortems, to give a clear and transparent record of what took place, and, most

importantly, what briefing the pathologist may have had from the police in advance of the examination. As one family member told this review:

“Misconceptions about his [the deceased’s] position in the van were given to the pathologist as factual evidence and affected the conclusion.”

- 16.25 It should be noted however that the existence of a video record of the post-mortem should not be used as a reason not to have a second post-mortem if it is required. The purpose of a second post-mortem is not to confirm the findings of the original examination, but is in itself a separate investigation that may look at areas that may previously have been overlooked.
- 16.26 Another very difficult issue for families is their inability to see, or touch, the body of their loved one before the post-mortem examinations are completed. There are valid, forensic and legal reasons why this must be the case. Some important samples may be taken from the body by pathologists at the post-mortem, as well as at the scene of the death, therefore allowing access to the body beforehand would risk contamination of forensic evidence and compromise the reliability of the results. It is however incumbent on the Coroner to ensure families understand these reasons and that they are given the opportunity where possible to view the deceased before the post-mortem examination takes place (through a glass screen if necessary or by CCTV camera monitor if available).

Disclosure

- 16.27 The process of disclosure, whereby the Coroner receives documents and evidence from relevant bodies, and in turn discloses them to interested persons on request, is vital for ensuring a thorough and effective Inquest, and indeed is an integral part of the justice system. It allows for open and transparent Inquests.
- 16.28 Given the many bodies that may be involved in an inquest, there is inconsistency in how disclosure is conducted among them. Under the Coroners (Inquests) Rules 2013¹⁵³, where an interested person asks for disclosure of a document held by the Coroner, ‘the Coroner must provide that document or a copy of that document, or make the document available for inspection by that person as soon as is reasonably practicable’. These documents include post-mortem examination reports, any other reports submitted to the Coroner during the investigation, and any other document that the Coroner deems relevant.
- 16.29 The IPCC also has duties of disclosure, and inevitably the police force and the CPS will also have extensive obligations to disclose evidence in advance of an inquest. In the absence of clear processes there is a danger that disclosure will not happen in a timely fashion. In written evidence to this review INQUEST stated that:

153 <http://www.legislation.gov.uk/ukxi/2013/1616/made>

“Sometimes critical, identified documents are not provided in advance and only become available during the course of the final inquest hearing. Frequently other unknown and previously undisclosed documents come to light during the course of the evidence. Such non-disclosure seriously hampers inquest preparation and the ability of legal representatives to probe the issues.”

- 16.30 It is not just families that have to contend with such delays. One Coroner told this review that they had experienced real difficulties getting full disclosure from the police. It was a hugely time consuming process, and in some cases repeated ignored requests verged on contempt of court.
- 16.31 It should be noted that the role of the Coroner is very different to that of a circuit judge. The role of the Coroner is not to establish ‘guilt’ but to conduct an inquisitorial hearing to establish the facts of a case. They are concerned with establishing ‘causation’ as well as looking at how to avoid future deaths. The Coroner is responsible for deciding what evidence to disclose based on a relevance test in the 2013 Rules although the High Court has a supervisory jurisdiction on these matters. Coroners alone have to physically decide on disclosure for every single document or part of a document. For example, the IPCC routinely provides the Coroner with transcripts of interviews, not summaries. The Coroner must go through the time consuming process of teasing out relevant information line by line from the original transcripts to determine the relevance and need for disclosure. Lawyers acting for interested parties may also interrogate the evidence and make submissions to the Coroner on relevance.
- 16.32 The rules on disclosure are set out in rule 13 of the Coroners (Inquests) Rules, 2013, but some supporters of families are concerned that the relevance test allows for too much discretion on the part of the Coroner, who may refuse to disclose any document that the Coroner deems irrelevant to the investigation, or if they feel the request is ‘unreasonable’. This allows for a degree of interpretation which, in the absence of a national framework, could lead to inconsistent approaches in different jurisdictions. The Chief Coroner should consider issuing guidance on what constitutes an irrelevant or unreasonable request in order to assist a consistency of approach.

Coroners’ investigations

- 16.33 Most Coroners will rely solely on the findings of the IPCC before the commencement of the Inquest, and will not proactively seek additional evidence of their own. This is not universal, and some Coroners will instruct their own experts if they feel there are additional lines of enquiry. It may also be the case that the IPCC investigation is entirely sufficient.
- 16.34 One of the main reasons for the reluctance of Coroners to seek further evidence is the lack of resources referred to above. As has been referred to earlier in this chapter, some Coroners report feeling under pressure from local authorities not to rely on expert evidence in order to make savings. Coroners are obliged to notify the authority of any ‘unusual’ expenditure, but they do not need permission from them.

- 16.35 It may also be the case that Coroners are unwilling to add to delays, and are therefore reluctant to commission new evidence. The Coroners (Investigations) Regulations, 2013, provided a structure for ensuring timely inquests. The 2009 Act and the Coroners (Inquests) Rules 2013 states that Inquests should be completed within six months after the death has been reported to the Coroner (or as soon as practicable thereafter). Such a time limit is unlikely to be realistic for most deaths occurring in police custody.
- 16.36 In addition, Section 16 of the 2009 Act requires Coroners in England and Wales to notify the Chief Coroner of any investigation which has not been completed within a year of the death being reported to the Coroner. The Chief Coroner has reminded all Coroners of their duty to set dates for inquest hearings at the opening of an inquest. He has stressed the need for setting dates and having timely hearings, and that a delayed inquest may lead to formal disciplinary action.
- 16.37 This appears to be having some effect. In his *Third Annual Report: 2015-2016*, the then Chief Coroner, His Honour Peter Thornton QC, reported:
- “Since the introduction by the Chief Coroner in 2014 of a standard procedure for reporting to the Chief Coroner on cases over 12 months, there has been a decrease by 52% of cases outstanding. This is a reduction from 2,673 cases to 1,285 cases, a figure which is now little more than 0.5% of all deaths referred to Coroners in England and Wales.”*
- 16.38 This is very welcome, but should not detract from some of the dreadful delays and the resulting impact on families and individual police officers in cases involving deaths in police custody. There are no published statistics which show the length of time that deaths in police custody or following police contact take to get to Inquest, but it is likely that these cases will take much longer than others, especially as at the moment IPCC investigations in this category of deaths rarely take less than a year. They are therefore likely to fall within those cases that are still taking longer than a year to resolve. Delays may also be caused by the backlog of cases that require a hearing in court, as well as interim referrals to the CPS and requests for expert evidence.
- 16.39 It would also be helpful for evidence from the IPCC to be shared with the Coroner where possible as it is collected unless there are sound operational or legal reasons not to do so. Sometimes it is only at the inquest that a Coroner may discover something the IPCC has overlooked. This leads to further delays while those new issues are investigated.
- 16.40 The extent of the dependency of the Coroner on the efficacy of the other main participants is not acceptable and tests the viability of the Coroner’s role as an inquisitorial judge. If the inquisitorial nature of the Coroner’s role is to be more than superficial until the Inquest hearing commences, the Coroner must be capable of initiating his or her own investigations without complete reliance on third parties. While it would be nonsense to simply duplicate enquiries being carried out by the IPCC, the Coroner requires to have an autonomy in this context that is more realistic than theoretical. Better case management and coordination between all parties in general,

with regular updates to the Coroner during the various investigations could also help to speed up the process and allow the Coroner to determine if additional lines of enquiry should be pursued for presentation at the Inquest.

Pre-inquest reviews

- 16.41 As will be discussed later in this chapter, the atmosphere at inquests in these cases is generally adversarial. When one or several organisations find themselves under scrutiny an adversarial approach is all but inevitable given that prosecution or a finding of neglect or unlawful conduct may have very serious consequences for those held to have conducted themselves in those ways.
- 16.42 It may be possible to mitigate to some extent the adversarial environment by carefully using pre-inquest reviews (PIR) involving all interested persons to set the tone, focus the issues, ascertain what issues are not in dispute and outline what will be the lines of enquiry by parties at the Inquest. The PIR may also be used to set a tighter time scale for the parties to work towards thus avoiding unnecessary delay or adjournments of the inquest hearing.
- 16.43 A PIR is effectively a meeting convened by the Coroner involving all interested persons (including families) to discuss issues relating to the upcoming Inquest. The Coroners (Inquests) Rules 2013, state that “a Coroner may at any time during the course of an investigation and before an inquest hearing hold a pre-inquest review hearing”. Guidance issued by the Chief Coroner states that:
- 16.44 However, the effectiveness of pre-review hearings is entirely dependent on how well prepared all interested persons are, and this in turn is dependent on the individual Coroner. As INQUEST stated in evidence to this review:

“The purpose of a PIR is to ensure that the case is managed effectively, efficiently and openly. Before the 2013 Rules were introduced, it was intended that PIRs should provide the opportunity for the scope, issues and conduct of an inquest to be established. Families and other participants could raise issues, particularly contentious issues, on these and other key topics so that surprises could be avoided.”¹⁵⁴

“...there remains inconsistency in practice between Coroners, with some circulating agendas and draft agendas in advance whilst others do not, and some circulating a note of the PIR and directions following the hearing and others not.

“In many cases critical issues and decisions remain left until late on in the process, not unusually to the first day of the inquest, when they would be resolved in advance at PIRs, for example anonymity of police officers, use of CCTV in court, disclosure to the media, decisions on whether police officers may remain in court to hear their colleague’s evidence. Some issues are raised by police representatives for the first time at the start of the hearing.”

154 <https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-22-pre-inquest-review-hearings.pdf>

Family experience

16.45 The experience of attending at the scene of the death and then waiting for and attending an inquest is deeply traumatic for families. In many cases the grief and trauma of losing a loved one is compounded by the confusion and bewilderment of the unfamiliar, formal and sometimes hostile atmosphere of the Coroner's court. Without help and support the inquest may be an intimidating experience. The experience of one family member who gave evidence to this review is instructive:

"We had to do everything ourselves. We had no lawyer at the inquest. Those three weeks were the most terrifying thing I've ever done in my life. I had to cross examine witnesses, it was absolutely terrifying, and they had lawyers. There needs to be a level playing field; a family member should never be put through that."

16.46 The Government provides guidance to Coroners services¹⁵⁵, and INQUEST also provide support and guidance materials. This includes the *INQUEST Handbook* which provides detailed advice to families on all aspects of the process, from the post-mortem through to the Inquest itself.

16.47 Families may also obtain support from the Coroners' Courts Support Service (CCSS). This is a registered charity whose volunteers give emotional and practical support to families and other witnesses attending inquests. CCSS volunteers can take families into the Court before the proceedings start and explain how an inquest is conducted and the layout of the Court. CCSS is a potentially useful means of help in demystifying the process, although it in no way serves as any form of substitute for full legal representation in Article 2 death cases in police custody.

16.48 The physical environment of the court can itself be a major factor in how families perceive the process. Most Coroners do not have their own courts. Not all courts are equipped to give space to families where they need moments of privacy. This may be particularly necessary in lengthy cases that may last several weeks. Smaller courts may also not be able to reserve seating sections for family members, who may have to sit in close proximity to police officers who may have been involved in the death of their loved one. Whilst understanding that not all buildings are the same and have the same resources, there needs to be a consistency of approach. Court facilities must be fit for purpose.

¹⁵⁵ <https://www.gov.uk/government/publications/guide-to-Coroner-services-and-Coroner-investigations-a-short-guide>

Inequality of arms

16.49 Perhaps one of the most visible examples of the imbalance that can exist in the coronial process is that of the inequality of arms during many inquests. Currently, the family of the deceased has no automatic right to funding for legal representation. Guidance from the Ministry of Justice states:

“In most cases you will not need to instruct a solicitor to represent you at an inquest, although you may do so if you wish. An inquest is a fact-finding process and the Coroner will ensure that the process is fair and thorough, and that your questions about the facts of the death are answered.”¹⁵⁶

16.50 This advice is very unhelpful in the context of a death in police custody. Families need a lawyer to ensure they are able to play an effective role in the process. The combination of grief, trauma and lack of familiarity with the rules and procedures of the Court make it wholly unfair for families to represent themselves during the whole process.

“Families need a lawyer to ensure they are able to play an effective role in the process. The combination of grief, trauma and lack of familiarity with the rules and procedures of the Court make it wholly unfair for families to represent themselves during the whole process.”

16.51 For inquests, Legal Help (the means tested advice and assistance level of legal aid) is available to family members of the deceased. This can cover all of the preparatory work associated with an inquest, for example to help families prepare written questions they would like the Coroner to ask. Legal representation at the inquest itself is only available through the exceptional case funding (ECF) Scheme and is provided only where certain published criteria are met.

16.52 Such help is currently means tested. The process for applying for help is felt by many families to be intrusive and complex. In written evidence to this review, Marcia Rigg, the sister of Sean Rigg, stated:

“Non-means testing of entire family households for access to legal aid and legal representation at the coroner’s inquest should be a foregone conclusion...Families have lost their life savings, including me.”

16.53 Families who spoke to this review also told of how the means testing process had affected them:

“Costs were discussed and we were asked to pay £8000 for legal aid. We had to fill in forms to declare savings. R didn’t declare a bank account, it was very invasive but R said “I’m not telling them about money we worked hard for.” We got the MP involved, he was brilliant. He talked about it in Parliament. Why should I pay to hear what’s been done to our son?”

“They delved into our private lives. We felt we were being investigated, but we are the victims here”.

“We didn’t qualify for legal aid. Exceptional funding was refused three times. The MP got involved. We finally got it and we had to pay £5000. The costs would have been £50k-£60k even at legal aid rates. I feel incredibly strongly that legal aid must be given automatically as a right, not means tested”.

“Funding should be available across the board and no issue about income streams. State bodies have the best legal representatives money can buy. I can sell my house, but I’d rather not be in this position after everything else I’ve been through”.

“It doesn’t matter who you are, you deserve justice. Money should not be involved because it’s not your own choice to have the process”.

16.54 In addition, barristers from Doughty Street Chambers told this review:

“...the processes by which financial eligibility is determined is often intrusive, lengthy and upsetting. Currently, applicants who wish to obtain both Legal Help in the run-up to the inquest and advocacy services at the inquest itself must go through two different processes. The process causes some families to withdraw from the process altogether while others report family conflict because of intrusive questioning of their financial circumstances irrespective of whether individual family members had any relationship with the deceased. Many families are excluded from such support simply by virtue of the fact that they own their own home, even if this does not mean in real terms that they have substantial disposable income to be spent on legal fees.”

16.55 By contrast, all of the various branches of the state will attend inquests bristling with senior barristers and solicitors to represent them and ultimately, all paid for by the taxpayer. For example, at the Inquest into the death of Darren Lyons which opened on 31 October 2016, there were eight separate legal teams as well as the family’s lawyer.

Staffordshire Police, Nestor Primecare (responsible for the health and forensic services to Staffordshire Police) and G4S (responsible for the Custody Detention Officers) were all represented at the Inquest. Three individual police officers, one nurse and one civilian detention officer were also separately represented. Often, a bereaved family will be fortunate to have a sole representative, and in many cases may have had to meet the costs themselves.

- 16.56 The reason that families have no automatic right to state funding for legal representation, is based on the belief that inquests are inquisitorial processes, designed to discover the facts of the case, and not apportion blame. It is therefore argued that there is no inherent reason why a family needs to be represented by a lawyer, and indeed the Coroner can ensure that the families' interests are looked after. The Coroner has a duty to ask difficult questions and can encourage families to put their own questions in writing in advance. They can then select pertinent questions and ensure they are asked. This premise is wholly unfounded.
- 16.57 The reality is that Inquests into death in police custody are almost always adversarial in nature. This has been the unanimous opinion of Coroners, lawyers and families who have given evidence to this review. There is nothing inherently wrong with an adversarial approach as it may be the best way to robustly test evidence in court. However, it needs to be recognised as such. The expectation that the Coroner can meet the family's interests during the inquest is wholly naïve and unrealistic as well as unfair to families and to the Coroner.
- 16.58 It is difficult to justify the belief that families do not need a solicitor to represent them when several individual state bodies at the Inquest hearing are routinely represented in contentious Article 2 cases by their own Queen's Counsel, who are very senior lawyers. To a family appearing at an inquest, seeing the scale of legal representation for the various branches of the state does little to enhance their faith in the process.

“It is difficult to justify the belief that families do not need a solicitor to represent them when several individual state bodies at the Inquest hearing are routinely represented.”

16.59 The adversarial nature of inquests where someone has died in police custody has led, on occasion, to hostile and insensitive questioning of family members by QCs or barristers representing the state. One family member in oral evidence to this review spoke of their experience:

“I was treated very badly. I was a witness and the police barrister had me on the stand for three and a half hours. He battered me literally with questions. He accused me of not caring about my son, he was shouting at me, slamming books, was so aggressive. The Coroner did nothing for a long time. He was asking very offensive questions and only after three and a half hours the Coroner said “okay that’s enough now”.

16.60 Such an experience is not uncommon according to the many families who spoke to this review. Clearly families cannot be expected to represent themselves at an Inquest. It is manifestly nonsense to assume that a grieving family could undertake the process of sifting through many hundreds of pages or volumes of evidence in order to formulate pertinent questions, and indeed, face hostile questioning without support. This is not a reflection on their intellect but on the impact of grief, anxiety and the sheer volume and complexity of absorbing material while suffering.

16.61 Under the current system the Coroner has a duty to try to level the playing field, but in practice it is not always possible. The Coroner needs to go the extra mile to help if a family are unrepresented. This lengthens proceedings, and increases costs. Therefore it may be a false economy to not automatically fund families. There is also a danger that if a Coroner is seen to be too helpful to a family they will be perceived by other participants to lack impartiality. This makes it harder for justice to be seen to be done. This is supported by the former Chief Coroner who stated in an interview with *The Guardian* on 25 July 2016 that:

“It’s partly a question of equality of arms and also helps the coroner who might otherwise be bending over backwards to help the family and might give the appearance of going too far,”¹⁵⁷

16.62 There are also additional reasons why it is desirable for families to have the right to automatic non-means tested funding for legal advice and representation from the earliest point following the death. Firstly, families need to be advised of their rights as soon as they are advised of the death and provided with legal support about the processes. It should be remembered that the process of application from families for legal help can be incredibly stressful for families awaiting a decision. If funding was automatic this would remove such anxiety.

16.63 Secondly, although the ambit of an inquest is currently to determine ‘in what circumstances’ the deceased came to die, there is some scope for Coroners to narrow the scope of an investigation, or even shut down certain aspects of a case. Legal representation would allow the families to challenge this, if appropriate, before the inquest was held.

157 <https://www.theguardian.com/law/2016/jul/25/chief-coroner-calls-for-legal-aid-provision-in-state-involved-inquests>

- 16.64 Thirdly, during the Inquest legal debates may take place and at the end of sometimes lengthy inquest hearings, counsel for participants are invited to make legal submissions to the Coroner. This is a very important part of the process often dealing with highly complex legal matters, addressing issues for jury determinations and prevention of death reports. Families acting alone cannot possibly be expected to make such submissions.
- 16.65 The Government should consider what the appropriate model of funding should be, but precedents include the bespoke schemes set up by the then Home Secretary to provide funding for legal representation for the families of the deceased at the Hillsborough Inquest, or the Potters Bar rail disaster where the Department for Transport administered a similar bespoke scheme.

Prevention of future deaths

- 16.66 It is the desire of families of the deceased for action to be taken so that future deaths are prevented. It is therefore significant that the Coroners and Justice Act 2009, made it a duty, rather than a 'discretion', for Coroners to produce Prevention of Future Deaths (PFD) reports following inquests where clear lessons can be learned.
- 16.67 Such reports are not routinely disseminated to organisations or individuals who should or must be made aware of the terms and implications of the report (although all are published online by the Chief Coroner). For example, there is no mechanism for these reports to be routinely sent to police forces or the College of Policing which would be in a position to consider whether the report's conclusions should inform their national training. There is also no follow-up to see what, if any, findings interested parties had taken forward. As a result, it is difficult to know if action is taken in response to reports, training materials are being updated, or even if there is the most cursory awareness of the Coroner's findings.

A National Coroner Service

- 16.68 The Coroner's system in England and Wales consists of 92 Coroner areas, and 380 Senior, Area and Assistant Coroners (some full-time, some part-time). Funding comes from the relevant local authorities. While the introduction of the role of Chief Coroner is a significant advance for the system and the Chief Coroner attempts to set national standards, inconsistencies in approach are inevitable while the system remains fragmented. Since the Coroners and Justice Act 2009 all Coroners have to be legally qualified although there are still coroners in the system who are medically qualified only. The variance of skills and experiences brought to the role by Coroners will inevitably lead to different approaches.

16.69 The 2009 Act also includes valuable provisions that have not yet been implemented and which could support improvement even within the existing structures. Section 39 would introduce the power to inspect non judicial aspects of the Coroners' system and Section 40 creates a right of appeal to the Chief Coroner against certain decisions by the Coroner.

16.70 Inconsistencies of approach affect all aspects of an inquest. In addition to those issues already raised, there are other areas where there is potential for inconsistent approaches at inquests. For example, Coroners are obliged to put questions to jurors from the outset to identify potential conflicts of interest; they must also give opening statements to the jury. According to INQUEST, based on its experience and casework, these obligations vary in detail and length depending on the Coroner. Similarly the quality of summing up and direction to juries may also vary greatly. While judicial independence is critical to the system and uniformity is not expected, some general consistency of approach should be expected.

16.71 Such inconsistency was reflected in the experiences of families who spoke to this review. Many had very positive things to say:

"The Coroner was great and his associate told me more than the IPCC, I would speak to her daily, but it's not her job, should be someone else. After the first post-mortem or the second post-mortem, the Coroner's assistant rang to tell us that the initial findings were inconclusive; she came to our house and explained."

"The Coroner was very helpful. The day after we were helpless, how can we get help, where do we start? The Coroner told us the questions we needed to ask."

"She was fantastic. First person who said "I'm so sorry". She was the first person who made a link with us."

16.72 Others however had different experiences:

"The Coroner was okay. He did stop when things were getting bad (during what the family described as very aggressive questioning by the police barrister), but he seemed to be on the side of the police."

"A friend said to me you need to get a second post-mortem, it has to go through the Coroner. The Coroner brought us in for a second meeting, not a very pleasant experience. Fortunately he's retired. He said "why do you want another post-mortem." I said, "I want to know the truth. He said, "It's very costly, you won't understand it". This to a mother who has just lost a son."

16.73 To address inconsistencies in approach and the quality of the process there have been many calls over the years for a National Coroner Service, including in the recommendations of The Shipman Inquiry Third Report, 2003¹⁵⁸. In addition, the 2006 House of Commons Constitutional Affairs Select Committee report, *'Reform of the*

158 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf

Coroners' system and death certification' expressed doubts about the ability of the then proposed role of Chief Coroner to remedy inconsistencies within the Coronial system in the absence of a national structure:

"The limitations of the local structure of the current system, giving rise to uneven distribution of resources, will remain. It is difficult to see how a Chief Coroner can function effectively as a force for standardisation without being part of a national service. A national service would almost certainly involve significant extra cost, but the failure to introduce one will mean that the current inequalities of resource will continue."¹⁵⁹

16.74 These recommendations were not accepted by the Government but instead the role of Chief Coroner was created by the Coroners and Justice Act 2009, to provide national leadership for Coroners in England and Wales and to set national standards for all Coroners, including new inquest rules. In a meeting of the All-Party Penal Affairs Parliamentary Group of 5th November 2013, the Chief Coroner stated:

"This has been a long time in the making. The Broderick Committee in 1971, Tom Luce and his review in 2003, Janet Smith in her Shipman Report in 2003, all called for a national Coroner's service, funded by government, led by a Chief Coroner with appellant powers. Well, you have got the Chief Coroner, but not the rest."¹⁶⁰

16.75 The then Chief Coroner also reiterated his support for a national service in his *Third Annual Report: 2015-2016*:

"There have in the past been calls, as in the report of Tom Luce's Fundamental Review, Death Certification and Investigation in England, Wales and Northern Ireland, for a national service, with coroners to be appointed and the service funded and run centrally, like other judicial services. But that has not happened.

"The Chief Coroner supports these calls for a national service. Much would be gained, in terms of standardisation, consistency and the implementation of reform, by a national structure."

16.76 The line between the inquisitorial stance of 'fact not fault finding', the more adversarial Article 2 obligations of ensuring effective scrutiny of key central issues and the need to 'ensure culpable and discreditable conduct is exposed' may not be well understood by inexperienced Coroners more used to dealing with routine deaths. In some jurisdictions contentious and high profile Article 2 inquests are rare and the Coroner may have no or little experience of sitting with a jury.

159 <http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/902i.pdf>

160 <http://www.prisonreformtrust.org.uk/PressPolicy/Parliament/AllPartyParliamentaryPenalAffairsGroup/Nov2013ReformingtheCoronerService>

- 16.77 To address these issues, a National Coroner Service would allow for the creation and training of a specialist cadre of ticketed and specialist Coroners to preside over deaths in custody Inquests, similar to the existing cadre of specialist Coroners who deal with the deaths of service personnel. Such a cadre would allow for the sharing of resources and have greater scope to communicate with families and ensure prompt hearings. This would end the need for inexperienced Coroners to preside over such cases, and would act as a legal counterbalance to state agencies who routinely appoint highly specialised and experienced QCs in Article 2 cases to act on their behalf. In the absence of such a cadre it is important that coroners presiding over such cases have sufficient experience and expertise.
- 16.78 It is time to look again at a National Coroner Service. Such a service would be better placed to enhance the independence of Coroners, embed learning, ensure the capacity of Coroners to carry out their own investigations without total reliance on third party organisations, uphold standards and promote a consistency of approach and resourcing across England and Wales.

Recommendations:

- Following a death in police custody the police should immediately advise the Coroner as well as the IPCC of the fact and whereabouts of the death, and preserve the scene of the death from any potential interference.
- The Coroner and IPCC staff should tell families immediately following the death of their right to independent free specialist legal advice, the benefit of securing advice from the earliest possible stage and the right to representation of a pathologist at the post mortem or to request a second post-mortem
- There should be access for immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the Inquest hearing. Families should be made aware of this right at the point when they are advised of the death and by the IPCC
- Consideration should be given to the creation of statutory time limits for the investigation by the agencies unless there are to be criminal charges made and the Coroner suspends the Coroner's investigation. These time limits should be set by the Coroner following receipt of the report of the early meeting between the agencies. A pre inquest hearing should be set before the expiry of that time limit or on cause shown in the event of a significant reason why the time limit cannot be met.
- Urgent consideration should be given to the mandatory video and audio recording of post-mortem examinations in contentious Article 2 deaths, with strict respect given to the control, storage and disclosure of recorded images. Wherever possible, such examinations should not take place until the family's chosen pathologist is in attendance. The video would serve as a record of the post-mortem but should not be used as a reason not to hold a second post-mortem examination if it is warranted.
- The Coroner should provide information to families about the post-mortem examination before it takes place – including the time and location of the examination, and their right to have a representative present, and all other associated rights.
- The 2013 Coroners (Investigations) Regulations should be amended to allow for a second post-mortem examination as of right, paid for by the state, in circumstances where no contact has been made with the family before the first post-mortem occurred, except for exceptional circumstances where all reasonable efforts were made to contact the family in advance.
- There should be a presumption that families should have access to the body of the deceased as soon as possible, even if this has to be through a screen or CCTV. Where this is not possible, the reasons must be explained clearly to the relatives with all necessary empathy, discretion and awareness of cultural and religious

sensitivities. Steps should be taken to allow access as soon as possible once the forensic examination is complete and once it has been determined that a second post mortem is not to follow.

- Written information about sources of specialist support and legal advice should be passed to every family by the Coroner's Officer at the very first contact. The Police and IPCC should also be subject to a legal obligation to advise the family of this right immediately on advising the family of the death. This may require translation services if English is not the first language.
- The Chief Coroner should consider issuing guidance on what constitutes disclosure of relevant information and, subject to the superintendence of the High Court, how Coroners should approach the issue.
- Families should be provided with a private space for the duration of an inquest and treated with respect and dignity. There should also be designated family space within the courtroom itself.
- The Chief Coroner should issue formal guidance to Coroners to prevent inappropriate or aggressive questioning of next of kin by counsel for interested persons at Inquest hearings. Coroners should be trained to be able to identify and prevent such styles of questioning where necessary.
- A nationally funded National Coroner Service should be urgently considered as a means to address persistent inconsistencies of service and the inability of Coroners to pursue investigations without complete reliance on the IPCC and other agencies.
- A specialist cadre of ticketed and experienced Coroners should be created to preside over Article 2 inquests, under the auspices of a National Coroner Service.

17. Sustained Learning

17. Sustained Learning

Introduction

- 17.1 Article 2 of the European Convention on Human Rights performs a vital function in the legal system of England and Wales. By obliging ratifying states to have independent investigations of deaths where there has been state involvement it provides the opportunity to uncover institutional failings and potential wrongdoing against individual citizens on the part of individuals who are agents of the state. The effectiveness of this process is critical if action is to be taken to prevent future deaths. Such investigations, including the inquest hearing, should be seen as a chance to put things right for the future and ensure that failures are not repeated.
- 17.2 However, looking at the conduct of many such inquests over several years it is clear that the default position whenever there is a death or serious incident involving the police, tends to be one of defensiveness on the part of state bodies. Families of the deceased often feel they are not treated with the same respect and dignity as victims in the criminal justice system, and sometimes even feel as if they are under suspicion themselves. The tendency of individual state agencies to attend inquests represented by their own barristers and legal teams who go on to adopt an adversarial style of advocacy, does nothing to reassure the public that the inquest is truly an inquisitorial process concerned with establishing the truth.

“Families of the deceased often feel they are not treated with the same respect and dignity as victims in the criminal justice system.”

- 17.3 Learning is important, but accountability must also be addressed through the disciplinary and criminal system where there are failings amounting to offences.
- 17.4 This was supported by a police officer who took part in the public consultation to this review, who stated that, *“a culture of openness and reporting when things go wrong can lead to a much safer environment.”* The extent to which the police, and other state agencies, foster a culture of openness is unclear. Procedures in place to support whistleblowers would help in this process, but it is not clear which of the 43 Forces in England and Wales have clear procedures in place to allow concerned officers to speak out.

17.5 Of course it should remain the case that where there have been serious failings or criminal behaviour there needs to be a proper investigation with appropriate charges or misconduct proceedings as necessary. Some Coroners and lawyers believe that an adversarial Inquest process is more likely to disclose the truth of what happened provided there is equality of arms. If, for example, a police employee, or healthcare worker faced misconduct action, or a police force or Chief Constable could be prosecuted or sued for corporate manslaughter, it is not surprising that a defensive stance is taken (unless the evidence was overwhelming). Notwithstanding this scenario, a general cultural shift towards learning lessons, would be an important step towards sustained learning.

A coordinated approach

17.6 It is also notable that there have already been many national investigations and reports looking at these issues. Recommendations from past reports have not always been followed up in a coherent or joined-up way. There is no single national body that can monitor progress and maintain the momentum and pressure for institutional change. As a result, progress tends to be piecemeal.

17.7 For example, recent years have seen the publication of:

- *Learning from Death in Custody Inquests: A New Framework for Action and Accountability*, INQUEST, 2012
- *Independent Commission into mental health and policing*, Lord Adebowale, 2013
- *Mental health crisis care: physical restraint in crisis*, MIND, 2013
- *A criminal use of police cells?*, HMIC/HMIP, Care Quality Commission and Healthcare Inspectorate Wales, 2013
- *Review of the operation of Sections 135 and 136 of the Mental Health Act*, Department of Health, Home Office, 2014
- *Review of the IPCC's work in investigating deaths*, IPCC, 2014
- *Preventing Deaths in Detention of Adults with Mental Health Conditions*, Equality and Human Rights Commission, 2015
- *The welfare of vulnerable people in police custody*, HMIC, 2015

17.8 These reports made a variety of recommendations concerning issues relating to deaths in police custody, all of which are also covered in this report. The same failings, and the same issues, appear to manifest themselves time and again. Nothing in these reports is new, and nothing found during the course of this review was unknown to experts who have followed these issues for years. It is damning that the same issues are still being discussed.

- 17.9 Good local initiatives by police forces are not being embedded nationally. The service offered by Coroners varies considerably from region to region in terms of funding and staffing and there is no coordinated way for Coroners to share best practice (although the Chief Coroner can issue guidance). Reports on Action to Prevent Future Deaths issued by individual Coroners are published by the Chief Coroner on line but there is only limited dissemination otherwise. The Coroner cannot follow up the response to the Report and there is rarely any follow-up by other agencies. These are just some examples of the lack of consistency of approach and assured learning from these deaths at a national level.
- 17.10 This leads to huge frustration for families of the deceased who are anxious that no one in future should have to experience what they went through. Only by the proper implementation of actions, in a nationally coordinated way can this be achieved.
- 17.11 There are good examples where organisations are attempting to share their learning in a more coordinated way. The College of Policing, Her Majesty's Inspectorate of Constabulary (HMIC) and the Independent Police Complaints Commission (IPCC) signed a concordat¹⁶¹ in 2014 aimed at 'promoting and monitoring best practice and continuous improvement in policing, in order to ensure public confidence'. The concordat states that:
- "The IPCC will share with HMIC information on themes and trends from across its cases. HMIC will take this into consideration when identifying potential themes for inspection...The IPCC will also share with HMIC recommendations that it makes to individual forces or nationally.*
- "The College will engage with the IPCC early in the scoping of requirements, and subsequent development of any new or revised standards, guidance or training, in order to ascertain whether the IPCC can signpost recommendations or provide other insight from its cases to add to the College's evidence base for its work."*
- 17.12 It is important that the College of Policing, IPCC and HMIC continually evaluate the efficacy of the concordat to ensure that it is working as intended and make public its findings in the interests of transparency and public confidence.

161 <https://www.justiceinspectorates.gov.uk/hmic/publications/concordat-between-the-college-of-policing-hmic-and-the-ipcc/>

Learning from investigations and inquests

- 17.13 Article 2 investigations and Coroners' inquests remain the single best systems for independently assessing what has happened when someone dies in custody, and what lessons can be learned.
- 17.14 The late Lord Bingham recognised the importance of post death investigations in an October 2003 ruling in the House of Lords relating to the racist murder of Zahid Mubarek, in a Young Offenders Institution. While this case does not fall under the gamut of deaths in police custody, the conclusions identified by Lord Bingham on the importance of investigations is germane to this review:
- “The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.”*¹⁶²
- 17.15 This view is also supported by the Chief Coroner who stated in his guidance on Reports to Prevent Future Deaths:
- “These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: ‘His death was tragic and terrible, but at least it shouldn’t happen to somebody else’”*¹⁶³
- 17.16 Inquests also have the ability to prompt wider reform and progress. Evidence emerging from the inquest into the death of Sean Rigg led directly to the Adebowale Commission on mental health. The Metropolitan Police Service (MPS) Central Mental Health Team has worked hard to develop the report's recommendations, and according to the MPS, Lord Adebowale has stayed very much involved in the work they have been doing and is said to be pleased with the progress.
- 17.17 The Inquest into the death of Sean Rigg also prompted the IPCC to launch an independent review of its investigation, led by Dr Silva Casale. Her recommendations were co-opted into the IPCC's own action plan for change, and its ongoing reform. Inquests therefore can uncover evidence that illuminate parts of the system in need of reform, and are crucial in identifying what lessons can be learned. They also act as 'checks and balances' on the investigations carried out by other agencies, can test the evidence and elicit further evidence, as in the case of Sean Rigg, where the initial investigation was flawed.

162 <http://www.publications.parliament.uk/pa/ld200203/ldjudgmt/jd031016/amin-1.htm>

163 <https://www.judiciary.gov.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf>

- 17.18 It should therefore be apparent that Coroners' Reports on Action to Prevent Future Deaths (PFD) should be as widely disseminated as possible. This is not currently the case. They are not even directly disseminated to other Coroners, but are made available on the Judiciary website¹⁶⁴ but not in a searchable format. There is no mechanism to follow up reports. The former Chief Coroner also accepted that his office was not resourced to do any thematic work on the reports.
- 17.19 In oral evidence given to this review, the College of Policing stated that they do not routinely receive PFD reports. Indeed, there were only two occasions that the Coroner had sent the Report to the College, because there were specific recommendations relating to training issues. The College believes that routine dissemination would be valuable as it would help highlight areas where there are currently deficiencies. When it comes to systemic changes such as training or changes in procedure, a national body such as the College of Policing comes within the scope of organisations who should receive PFDs. However, most Coroners only consider local bodies and not national bodies when they circulate the reports.
- 17.20 Current guidance for Coroners on dissemination of PFD reports states that:
- "The Coroner has a duty to report ('must report') the matter to a person or organisation who the Coroner believes may have power to take such action."*¹⁶⁵
- 17.21 This would seem to limit the recipients of any report to only those people in a position to act on recommendations. Whilst this should be expected as a minimum, it does not mean that other groups would not also benefit from reading the report. It is also the responsibility of the Coroner to make a judgement about who the report should go to. A national framework for the dissemination of PFD reports would take this decision out of the hands of Coroners, and allow for the wider sharing of the findings of the inquest.

An Office for Article 2 Compliance

- 17.22 There are many learning materials produced by a range of interested organisations, as well as recommendations from previous reports on the subject of deaths and serious incidents in police custody.
- 17.23 For example, since October 2014, police forces and other organisations have been required to respond formally to IPCC learning and recommendations. The IPCC then publishes a summary of its recommendations together with the official force response which are published on the IPCC website.¹⁶⁶ However, no one is responsible for following up these recommendations. Nor are Coroners able to follow up or enforce recommendations in their PFD reports.

164 <https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-Coroner/pfd-reports/>

165 See Chief Coroners Guidance No.5 (as above)

166 <https://www.ipcc.gov.uk/recommendations/archive>

- 17.24 As stated above, the IPCC also has a concordat with HMIC and the College of Policing that ‘captures and formalises arrangements for collaborative working between our organisations’. They also work with other organisations to produce ‘Learning the Lessons’ bulletins each year. These are bulletins which use case studies from IPCC investigations to illustrate good practice and learning.
- 17.25 This learning is from just one organisation. When taken into account with additional materials from police forces, the College of Policing, Coroners PFD reports, and guidance from the Independent Advisory Panel on Deaths in Custody (IAP), it can lead to ‘fatigue’ from police officers, Coroners and healthcare practitioners if they are being given numerous lessons to digest from a variety of sources. The volume of learning materials that exist may lack focus and impact in the absence of a national framework. The College of Policing, in written evidence to this review stated that:
- “There is some evidence to suggest that learning lessons still need improvement. In a 2013 study by Dr Kevin Pollock titled ‘Review of Persistent Lessons Identified Relating to Interoperability from Emergencies and Major Incidents since 1986’; after examining 32 major incident enquiries since 1986 concluded that lessons identified were not being learned and put into practice.”*
- 17.26 INQUEST have long called for a national oversight body that could be responsible for collating and disseminating learning. In evidenced to this review they wrote:
- “INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning and implementation arising out of custodial deaths. Any new framework must be accountable to Parliament to ensure the advantage of parliamentary oversight and debate. It must also provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.”*
- 17.27 Currently, only the Ministerial Council on Deaths in Custody exists as a means of coordinating policy, and disseminating learning for incidents of deaths in state custody and mental health detention in England and Wales.
- 17.28 The Ministerial Council on Deaths in Custody began work in April 2009, and is jointly funded by the Ministry of Justice, Department of Health and the Home Office. Its purpose is ‘to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales’.
- 17.29 The Council brings together ‘senior decision-makers, experts and practitioners in the field’ and consists of three tiers: the Ministerial Board on Deaths in Custody; the Independent Advisory Panel (IAP); and the Practitioner and Stakeholder Group (a ‘virtual’ group that supports the work of the IAP by providing advice and expertise for its projects).

- 17.30 The Ministerial Board on Deaths in Custody, includes all types of death in state custody, including prisons and immigration detention, not just those considered within the scope of this review. The Board brings together policy officials from the three funding Departments, and other organisations including HM Inspectorate of Constabulary, the Independent Custody Visiting Association (ICVA), the Independent Police Complaints Commission (IPCC), NHS England and the Office of the Chief Coroner.
- 17.31 The Independent Advisory Panel (IAP) role is to ‘provide independent advice and expertise to the Ministerial Board. It will provide guidance on policy and best practice across sectors and make recommendations to Ministers and heads of key agencies’. According to its website the IAP also has a formal role in disseminating learning, by:
- “...consulting and engaging with relevant stakeholders in order to collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them.”*
- 17.32 The work of the Council is coordinated by a single Secretariat responsible for all three tiers. It is therefore the Secretariat that acts as a central point for sharing learning and information about means of preventing deaths in custody.
- 17.33 Given that the Council has been functional since 2009 it would be appropriate to ask whether its work and the three tier structure is fit for purpose. In evidence given to this review, INQUEST (whose Director was a former member of the IAP panel, and attendee of meetings of the Ministerial Board) expressed concern that the Council lacked the necessary resources, capacity and independence to fulfil the role it was intended to do. INQUEST further stated:
- “Its Independent Advisory Panel (IAP) is a limited initiative. It does not have its own staff or resources to devote to in-depth work and is unable to compel the Ministerial Board to accept and act on its recommendations. The Ministerial Board is largely an information exchange forum consisting of quarterly meetings chaired by different Ministers. There is no systematic discussion of inquest outcomes and these are only discussed on individual cases if INQUEST as one of the representatives on the Board tables a discussion. The turnover of Ministers and Secretariat means that it lacks formal organisational memory and many discussions are repeated.”*
- 17.34 This review has covered an extensive and comprehensive range of issues, not just concerning policing, but also local government, the NHS and other health providers, and other agencies. In order that the findings of this review are properly taken forward, coordinated action taken over a sustained period of time within a broad range of agencies is required. It needs to be concentrated in one place with resources and organisational memory.

- 17.35 The Government and the Ministerial Council should consider whether a new body is required. This would potentially be an 'Office for Article 2 Compliance', which would require an independent secretariat and would need to be appropriately resourced.
- 17.36 As with the current Ministerial Council it would need to cover all deaths in state custody. There are other deaths in state facilities (for example prisons and immigration detention centres) which, whilst not covered by the Terms of Reference of this review, nevertheless share characteristics with police custody deaths. Inevitably there would be a cost associated with this, and it would be for the Government to develop the structure and legal standing of such a body. When considering cost however, it should be recognised that the current costs associated with long investigations, (sometimes reinvestigations) and inquests already comes with a significant financial cost, not to mention of course, the human cost.

Recommendations:

- The Ministerial Council on Deaths in Custody should conduct a review of its structures to consider whether those structures are suitable for purpose.
- The Government should consider whether there is a need for an independent Office for Article 2 Compliance, accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level. It should report publicly on the accumulated learning and compliance arising from Inquest outcomes and recommendations. It should provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.
- An Office for Article 2 Compliance should oversee a coordinated, methodical and routine process around the dissemination of Coroners' PFD reports and jury findings to all stakeholders, including (but not limited to) police forces, the College of Policing, the IPCC, and healthcare professionals.
- The Home Secretary should provide an annual update to Parliament on the progress of implementation of the recommendations from this review.
- Police and Crime Commissioners should report annually on deaths and serious incidents in police custody in their jurisdictions.

18. Summary of Recommendations

18. Summary of Recommendations

Recommendations are grouped thematically. The corresponding Chapter numbers are in brackets at the end of each recommendation.

Restraint

1. Police practice must recognise that all restraint can cause death. Recognition must be given to the wider dangers posed by restraining someone in a heightened physical and mental state, where the system can become rapidly and fatally overloaded. Position is not always the determining feature. As great a danger can arise from the struggle against restraint as the restraint itself. (2)
2. There should be mandatory and accredited national training for police officers in restraint techniques, including de-escalation and supervision of vital signs during restraint, with appropriate refresher training for officers. There should be national consistency in approaches to the use of force. (2)
3. The grave dangers of prone and other forms of restraint in and of itself must be reiterated within forces in an effective manner and re-emphasised in training and re-training by all forces. (2)
4. ‘Excited Delirium’ should never be used as a term that, by itself, can be identified as the cause of death. The use of Excited Delirium as a term in guidance to police officers should also be avoided. (2)
5. National policing policy, practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk. (2)
6. The restraint of anyone suffering a mental health crisis should be identified in national policy and training as a high risk strategy giving rise to a medical emergency. Where all else has failed or life threatening circumstances demand, it should be used for the very shortest time possible and an ambulance should be called for immediate transportation to Accident and Emergency (2)
7. Restraint equipment should be strictly limited and subject to robust monitoring and review. Its use should form part of the mandatory training. (2)

Custody environment

8. A mandatory safety officer approach should be implemented by all police forces similar to that used in the prison setting. (2)
9. CCTV should be introduced in police vans nationally to allow monitoring of restrained detainees, in conjunction with vigilant supervision of welfare and safety during transport. Failure to maintain and ensure its proper functioning should be a disciplinary issue. Unforeseen CCTV failures should not result in a van being taken out of service if a detainee requires urgent transportation. (2)
10. HMIC should include a focus on inspection of observation regimes for intoxicated detainees within its Expectations of Police Custody (updated April 2016). HMIC should monitor police forces' internal inspection procedures for observation regimes. (3)
11. Custody inspections should continue to focus on the use of liaison and diversion schemes, pre-release risk assessment, and actions taken on release, as part of the inspection regimes of police forces. (6)
12. Police forces should include medical input in the risk assessment process at the point of release, provided by the NHS (assuming medical services within police stations are brought within NHS commissioning). (6)
13. Local Authorities should ensure that they have reasonable systems in place to ensure that all police requests for accommodation, whether secure or non-secure, are accepted. Adequate funding must be made available for local authority overnight secure accommodation of children in police custody. (7)
14. Inspection findings on the continuing use of overnight detention should feed directly into a national framework that links to departments for health and local government. (7)
15. The use of police custody for children detained under section 136 should be brought to an end with all NHS Trusts required to make sufficient provision of health-based places of safety to meet this requirement. (7)
16. Increased funding is required for appropriate adult schemes within a national framework for commissioning. This should include improved training and consistency of Appropriate Adult services. (7)
17. Custody procedures should be developed to lessen the impact of separation of mothers from young children. For example, supervised telephone contact around childcare issues should be prioritised and visits with children and their carers facilitated for longer detentions unless the nature of the alleged crime or the ongoing investigation prevents this. There should be monitoring of the extent to which police bail decisions take account of caring roles and the effects on the likelihood of absconding. (8)
18. The Government should consider whether Independent Custody Visitors schemes should have governance within HM Inspectorate. (12)

19. Privatisation of detention services should be avoided. Where private service providers are used the training of their staff should be to the same standards, preferably carried out jointly with police staff. They should be subject to the same processes of inspection and monitoring as police staff to ensure all-round compliance. Protocols between private service staff and police staff should be fully embedded and employed in practice to avoid fragmentation of services. (12)

Health and wellbeing

20. Healthcare professionals should take primary responsibility for the conduct and safe management of restraint of patients in any healthcare setting. This should be part of NHS and police policy. In the absence of support from other agencies the police may have to intervene with some form of restraint, but its use should be strictly limited and subject to robust monitoring and training. (2)
21. An NHS initiative at the national level should examine whether to prohibit the refusal of access to A&E or to health-based places of safety under section 136 Mental Health Act 1983 (section 136) on the basis of intoxication. It should also consider the redesign of A&E facilities to allow for safe areas, to protect the safety of other routine patients and staff from those suffering from severe intoxication. (3)
22. The Government should give consideration to the viability and cost-effectiveness of drying out centres, and consider piloting a centre or centres in large urban areas where it is most likely to be cost-effective, and linking such centres to existing A&E departments. An alternative would be the fundamental redesign of A&E departments to take into account this challenging situation. (3)
23. Joint local protocols should be established between police forces, ambulance services and hospitals to ensure appropriate medical care for intoxicated people in the appropriate environment. (3)
24. The use of police vehicles for transporting people detained under section 136 should be stopped in all but the most exceptional of situations. These are health emergencies (particularly where force has been used) and an ambulance should be summoned for all section 136 detainees. (4)
25. The use of police stations as section 136 'places of safety' should be completely phased out. Guidance should not advocate the use of police custody on the grounds that a detainee's behaviour would be 'difficult to manage' in a healthcare setting. (4)
26. Successful local mental health policing pilots and initiatives, particularly street triage and liaison and diversion schemes should be funded on a sustainable basis for national roll out so that, as far as possible, those in mental health need are dealt with through medical and community based pathways not through police detention. Such schemes should be subject to regular review. (4)

27. There should be proper resourcing of national healthcare facilities to accommodate and respond to vulnerable people in urgent physical and/or mental health need coming into contact with the police. (4)
28. There should be clear procedures around the operation of section 136 from initial point of contact, including joint protocols between police, local health services and voluntary sector organisations. Health-based 'places of safety' should not be permitted to exclude those who are intoxicated or showing signs of agitated/aggressive/disturbed behaviour. (4)
29. An unambiguous and high threshold should be set for police involvement in any health care setting. Clear guidance should identify medical primacy of role in any health based setting involving the police. (4)
30. Independent investigations should always be held for all Article 2 related cases on NHS premises where there has been police involvement, or where someone died after contact with the police. (11)
31. Forensic Medical Examiners and other medical services within police stations should be brought within NHS commissioning, in order to introduce minimum standards of medical care in police custody and so that medical records of the individual are quickly available to the doctor. (12)
32. Local joint protocols should be in place between all forces and their local ambulance service, mental health services and hospitals around 'crisis planning', particularly in respect of detainees suffering a mental health crisis and/or disturbed behaviour. Implementation of the protocols should be reviewed regularly and all staff must be familiar and confident in the practices required by the protocols. (12)

Funding for families and family support

33. In order to facilitate their effective participation in the whole process there should be access for the immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the pre-inquest hearings and Inquest hearing. (15)
34. Written information about sources of specialist support, including information about INQUEST, should be given to every family at the very first contact with an IPCC representative, as well as alternative forms of information taking into account the needs of the individual next of kin. (9)
35. The Coroner and IPCC staff should tell families immediately following the death of their loved one of the right to independent free specialist legal advice, the benefit of securing advice from the earliest possible stage and the right to representation of a pathologist at the post mortem or to request a second post-mortem. (16)

36. This information should be regularly repeated during the progress of the investigation if the family have not sought legal advice at the earlier stage. The Coroner should provide information to families about the post-mortem examination before it takes place – including the time and location of the examination, and their right to have a representative present, and all other associated rights. (9)
37. Urgent consideration should be given to the mandatory video and audio recording of post-mortem examinations in contentious Article 2 deaths, with strict respect given to the control, storage and disclosure of recorded images. Wherever possible, such examinations should not take place until the family's chosen pathologist is in attendance. The video would serve as a record of the post-mortem but should not be used as a reason not to hold a second post-mortem examination if it is warranted. (16)
38. NHS Trusts should engage with families throughout their own investigations. There should be formal guidelines setting out the nature and expectations of family engagement. (11)
39. Where the NHS Trust is only one of a number of agencies investigating a death involving both police contact and NHS contact with the deceased there should be early, regular and formal communication and coordination with the IPCC and other agencies to minimise confusion, loss of evidence and delays. (11)
40. The Government should consider the feasibility of a scheme to pay reasonable travel and subsistence and compensation for loss of earnings for immediate family to attend the inquest in those inquests relating to deaths in police custody. Such a measure is necessary to ensure that access to the inquest hearing is a practical reality in every case. The Government should look at existing models, for example the support offered through Victim Support, when considering such a scheme. (15)
41. The Government should ensure that families have funded access to appropriate bereavement services offering specialist counselling to families of the deceased. Those providing the services should understand the impact of a traumatic bereavement involving a protracted, intrusive investigation. (15)
42. All state agencies who are engaged with the family, including police, IPCC, CPS and Coroners and their staff should provide both oral and written information about support services, including INQUEST, to families as early as possible when contact is established following the death. Agencies should not assume that this has already been done by others. (15)
43. Families should be provided with a private space for the duration of an inquest and treated with respect and dignity. There should also be designated family space within the courtroom itself. (16)
44. There should be a presumption that families should have access to the body of the deceased as soon as possible, even if this has to be through a screen or CCTV. Where this is not possible, the reasons must be explained clearly to the relatives with all necessary empathy, discretion and awareness of cultural and religious sensitivities.

Steps should be taken to allow access as soon as possible once the forensic examination is complete and once it has been determined that a second post mortem is not to follow. (16)

45. Written information about sources of specialist support and legal advice should be passed to every family by the Coroner's Officer at the very first contact. The Police and IPCC should also be subject to a legal obligation to advise the family of this right immediately on advising the family of the death. This may require translation services if English is not the first language (16)

Communications

46. Following a death in police custody the police should immediately advise the Coroner as well as the IPCC of the fact and whereabouts of the death, and preserve the scene of the death from any potential interference. (16)
47. IPCC staff should be vigilant about language and communication with families and of how their conduct and communication with police officers may be perceived by next of kin. Families should be invited to express concerns about anything said by IPCC staff which may give rise to doubts about independence. This should form part of the IPCC's learning and development around engagement with families. (9)
48. The roles of the Commissioner and the lead investigator need to be made clear to families in relation to all key aspects of the investigation from the earliest opportunity. (9)
49. In cases where the IPCC and HSE are actively involved, Coroners should hold prompt and regular pre-Inquest hearings requiring the agencies to liaise closely and account for the progress of their work and coordination. (14)
50. Before the IPCC has formerly taken over an investigation the police should make no public comment on the matter. Unless there are exceptional circumstances which require the urgent release of information the police should not issue any information to the media, but should leave this to the IPCC. (15)
51. Any information released to the media should be limited to very basic information about the deceased and the whereabouts of the death, and where possible, agreed in advance with the family, unless there are exceptional circumstances (for example a witness appeal) where time does not allow for this. (15)
52. Consideration should be given to the creation of statutory time limits for the investigation by the agencies unless there are to be criminal charges made and the Coroner suspends the Coroner's investigation. These time limits should be set by the Coroner following receipt of the report of the early meeting between the agencies. A pre-inquest hearing should be set before the expiry of that time limit or on cause shown in the event of a significant reason why the time limit cannot be met. (16)

53. Police and Crime Commissioners should report annually on deaths and serious incidents in police custody in their jurisdictions. (17)
54. The Home Secretary should provide an annual update to Parliament on the progress of implementation of the recommendations from this review. (17)

Investigations

55. Urgent consideration should be given to the development of an expert Deaths and Serious Injuries Unit of the IPCC for the investigation of all deaths in police custody in England and Wales. The Unit should be staffed by senior and expert officers from a non-police background. (9)
56. The IPCC should be resourced to provide a 24 hour national on call 'post incident' team with sufficient national coverage to ensure immediate response and attendance at a death or life threatening injury in custody within the shortest possible timeframe. Those attending should have experience of all steps necessary to protect a potential crime scene and secure evidence. The IPCC officer should be in constant contact with a senior member of the Deaths and Serious Injuries Unit for advice, guidance and further instruction until members of that Unit have arrived at the scene. (9)
57. IPCC investigators should consider if discriminatory attitudes have played a part in restraint-related deaths in all cases where restraint, ethnicity and mental health play a part (in line with the IPCC discrimination guidelines). A systematic approach should be adopted across the organisation. (5)
58. Ex-police officers should be phased out as lead investigators in the IPCC. To the extent that the IPCC still consider this expertise is required, ex-police staff should act as a consultancy and training source within and, more appropriately, outwith the organisation. The IPCC should also look beyond England and Wales for expert consultants and secondees from other investigative organisations who are also expert in the investigative, forensic skills required to investigate such serious cases, for example, from the Procurator Fiscal Service in Scotland and the Office of the Ombudsmen for Police in Northern Ireland. A wider pool of expert resources can also be considered by looking beyond the immediate jurisdiction of the IPCC. (9)
59. The IPCC should urgently consider whether to adopt a formal time limit for the completion of Article 2 investigations, with the lead investigator obliged to set out in writing why any extension to this limit was required. (9)
60. Police forces should be held accountable at the most senior level for protecting the scene when there is a death or serious incident in custody and preserving evidence until the arrival of the IPCC. Any failure to fulfil this role should be treated as a misconduct issue. Failure to maintain CCTV cameras and audio recording equipment in good working order should carry a disciplinary sanction. (9)

61. Investigations should maintain a strong focus on obtaining independent evidence, including prioritising CCTV coverage, mobile phone video recordings and the existence of independent witnesses during the immediate aftermath of an incident as well as appropriate instruction of experts. (9)
62. Body worn cameras should be rolled-out nationally to all police officers working in the custody environment or in a public facing role. (10)
63. The IPCC draft guidance on post-incident procedures relating to separation of officers and non-conferral should be accepted by the Government. (10)
64. Other than for pressing operational reasons, police officers involved in a death in custody or serious incident, whether as principal officers or witnesses to the incident should not confer or speak to each other following that incident and prior to producing their initial accounts and statements on any matter concerning their individual recollections of the incident, even about seemingly minor details. As with civilian witnesses, all statements should be the honestly held recollection of the individual officer. (10)
65. There should be a duty for police officers to provide a full and candid statement at the earliest opportunity and within the specified timeframe unless they are formal suspects. (13)
66. The IPCC should make clear in its guidance that minor discrepancies in statements given by police officers or any other witnesses to fact, are natural and are not presumed to be the outcome of dishonesty or incompetence. (10)
67. The Government should consider whether there is a need for a formal independent investigatory body for NHS Trusts in England and Wales. (11)
68. Where an individual dies during or following restraint involving both police and health personnel, a joint independent investigation by both the IPCC and the proposed independent investigatory body for the NHS should be closely aligned and coordinated in order to investigate the full circumstances of the death, including the conduct of the health personnel. (11)
69. Article 2 related cases should be dealt with in the same time scales as a civilian homicide case and the appropriate resources deployed by all agencies to achieve the completion of the investigation and decision making process within the robust timescale achieved in those cases. (13)
70. The CPS specialist unit handling prosecution decisions about deaths in police custody should be reviewed to ensure it is properly resourced with experienced prosecutors for consideration of such serious cases. (14)
71. There should be a formal meeting between the CPS, HSE, and IPCC within 14 days of a death or serious incident. This meeting should be chaired by the IPCC to discuss the emerging evidence, the probability and/or possibility of criminal charges and the nature of these charges, and be a precursor to regular cooperation and advice between these

bodies for the duration of the investigation. The meeting should set a timetable to be submitted to the Coroner. The liaison should be formalised through a Memorandum of Understanding. (14)

Coroners and Inquests

72. A nationally funded National Coroner Service should be urgently considered as a means to address persistent inconsistencies of service and the inability of Coroners to pursue investigations without complete reliance on the IPCC and other agencies. (16)
73. A specialist cadre of ticketed and experienced Coroners should be created to preside over Article 2 inquests, under the auspices of a National Coroner Service. (16)
74. The 2013 Coroners (Investigations) Regulations should be amended to allow for a second post-mortem examination as of right, paid for by the state, in circumstances where no contact has been made with the family before the first post-mortem occurred, except for exceptional circumstances where all reasonable efforts were made to contact the family in advance. (16)
75. The Chief Coroner should consider issuing guidance on what constitutes disclosure of relevant information and, subject to the superintendence of the High Court, how Coroners should approach the issue. (16)
76. The Chief Coroner should issue formal guidance to Coroners to prevent inappropriate or aggressive questioning of next of kin by counsel for interested persons at Inquest hearings. Coroners should be trained to be able to identify and prevent such styles of questioning where necessary. (16)

Accountability

77. Police must be held to account both at an individual and corporate level, where restraint has been found to have been used in an unnecessary, disproportionate or excessive way. (2)
78. The IPCC should address discrimination issues robustly within misconduct recommendations, including where discrimination is not overt but can be inferred from the evidence in that specific case or similar cases involving the same officer. (5)
79. In Article 2 related deaths the IPCC should consider making a formal written request for the restriction of duties (in misconduct investigations) and the suspension of officers pending the outcome of gross misconduct and/or criminal investigations, although the final decision should remain with the Chief Constable. (13)
80. The IPCC should publish criteria for deciding on whether police action amounts to misconduct or gross misconduct. (13)

81. The IPCC should be responsible for informing all interested persons as soon as a misconduct hearing is arranged. There must be adequate notice for a family to attend, and their rights should be fully explained. (13)
82. The Government should consider whether there is a need for a family's role at a misconduct hearing to be clarified, standardised and applied with more consistency, and advance disclosure of evidence to family members recognised as interested parties (subject to the harm test). (13)
83. Once clear criteria have been made open and transparent, dismissal should always follow findings of gross misconduct unless there are wholly exceptional circumstances which justify a different sanction. Such exceptional circumstances must be fully explained to the family. (13)

Training

84. Comprehensive and standardised mandatory police training is required across forces for custody sergeants, officers and civilian detention staff on the dangers associated with intoxication. This should include medical input. (3)
85. Training for privatised detention and medical services must be to the same standard as for police staff and include joint training with custody sergeants and other officers working in the custody environment. Joint training is also required for Forensic Medical Examiners and custody sergeants. (3)
86. Police recruitment and training should incorporate the different personal skills and experiences needed to fulfil duties relating to the needs of highly vulnerable groups, including empathy, communication skills and the ability to employ de-escalation techniques. This should be embedded in the police appraisal process with assessment made on the correct use of force and, in particular, where officers have been able to avoid the use of force. (4)
87. National, comprehensive, quality assured mental health training consistent with the above is needed for all officers in front-line or custody roles. This should span all new recruits and regular refresher training. Training should be interactive and should involve mental health users to help break down fears and assumptions. (4)
88. National policing bodies and police forces should implement mandatory training and refresher training on the nature of discrimination, including on race issues, which aims to confront discriminatory assumptions and stereotypes. Policing bodies should consult with bereaved families on how such training can break down barriers and promote change. Training should take the form of a two-way dialogue allowing officers to hear the experiences of people from BAME backgrounds and include participation of bereaved families. Police training should include an understanding of institutional racism, the Macpherson report, the social context of Black deaths in custody and the impact they have had on public confidence. (5)

89. The College of Policing APP on detention and custody and force training should include guidelines for pre-release risk assessment setting out specific practical steps that should be taken to provide support and protection for those at risk of self-harm on release (for example contacting family/carers before release with the detainee's consent, or referrals to community support groups). (6)
90. Police training and inspection should focus on utilising non-secure accommodation for children other than in exceptional circumstances, where children pose a risk of harm to the public. (7)
91. Mandatory police training on vulnerability must include understanding of, and appropriate policing responses to those with learning disabilities and difficulties, mental ill health, epilepsy or who are on the autistic spectrum as well as other conditions which may compromise the ability to communicate and understand police actions or processes. (8)
92. The use of support card schemes should be developed by all forces and included in police training. (8)
93. Police training should address the particular stressors that affect women detainees and young women in particular. Officers should understand the additional impact of these stressors upon women with mental health difficulties and the importance of access to healthcare. (8)
94. Families should be involved on an ongoing basis with the provision of staff training in the IPCC including training on the impact of a traumatic bereavement (9)
95. Police forces, the IPCC, CPS, Coroners offices and the College of Policing should give consideration to how family experiences can be brought into training and awareness packages. As a result of the tragic experience of the loss of a loved one in police custody many next of kin have become experts on a range of issues following a death in police custody and exposing officers to these families and listening to them is an invaluable training resource for all levels of command. (15)

Learning

96. Commitment and responsibility at leadership level is needed across police forces to ensure prioritisation of the issue of mental health and to bring about sustained cultural, organisational and practical changes. (4)
97. There should be consistent national police policy and guidance encompassing current learning and best operational practice, reflecting the need for a drastically improved policing approach to those in mental health need. (4)
98. The IPCC should ensure that race and discrimination issues are considered as an integral part of its work. This should be monitored and fed into internal learning and the IPCC's 'watchdog' role. (5)

99. The Ministerial Council on Deaths in Custody should conduct a review of its structures to consider whether those structures are suitable for purpose. (17)
100. The Government should consider whether there is a need for an independent Office for Article 2 Compliance, accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level. It should report publicly on the accumulated learning and compliance arising from Inquest outcomes and recommendations. It should provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work. (17)
101. An Office for Article 2 Compliance should oversee a coordinated, methodical and routine process around the dissemination of Coroners' PFD reports and jury findings to all stakeholders, including (but not limited to) police forces, the College of Policing, the IPCC, and healthcare professionals. (17)

Statistics

102. The national 'use of force' data collection must be continually reviewed to ensure it provides the necessary transparency, auditing, active monitoring and opportunities for learning and training absent from the current system. Monitoring of ethnicity and mental health should be part of that system. More meaningful information should be requested from forms recording use of force. (2)
103. There should be robust data collection on near misses and non-fatal serious incidents by the police and IPCC. (2)
104. The IPCC should monitor the correlation between ethnicity and restraint-related deaths, including in healthcare settings where the police were involved. Statistics should be published breaking down restraint related deaths by ethnicity. (5)
105. The national programme for police data collection on the use of force must include ethnicity and mental health (as well as other factors relevant to discrimination) in all force data so as to provide a standardised national picture. (5)
106. National data collection on the use of force should be analysed by the Home Office to draw out patterns and devise national strategies to address discrimination issues. The outcome of data collection and analysis should be made public. (5)
107. The IPCC should monitor ethnicity and deaths in custody against ethnicity and arrests by reference to all arrests, including non-notifiable offences. (5)
108. There should be mandatory ethnic monitoring of Gypsy Roma and Traveller communities in England and Wales by police forces in their ethnic monitoring systems. (5)

Research

109. Collaboration between pathologists, psychiatrists and emergency medicine practitioners is required to clarify and standardise the medical understanding around restraint-related deaths involving mental health crises. This should underpin future police training. An international conference and further urgent research is required to achieve consensus and better understanding. (2)
110. Independent international research should be carried out to look more closely at the safety of Conductive Energy Devices. (2)

Annex A: Meetings

Annex A: Meetings

During the course of the review Dame Elish Angiolini conducted meetings with the following people: -

Professor Louis APPLEBY CBE

Centre for Mental Health and Safety, University of Manchester

Dr Meng AW-YONG

Independent Advisory Panel on Deaths in Custody

Chris BATH

Chief Executive of the National Appropriate Adult Network

Inspector Michael BROWN

Mental Health Lead, College of Policing

Malcolm BRYANT

Legal Aid Agency

Lord Alex CARLILE

Chair of the Mental Health and Restraint Reference Group

Peter CLARKE CVO OBE QPM

HM Chief Inspector of Prisons

Professor Rafe FOREMAN

UMKC School of Law

Dr Peter GREEN

Vice President for Forensic Medicine, Faculty of Forensic and Legal Medicine

Lord Toby HARRIS

Former Chair of the Independent Advisory Panel on Deaths in Custody

Katie KEMPEN

Chief Executive of the Independent Custody Visiting Association

Rt. Hon. Norman LAMB MP

Chair, West Midlands Commission on Mental Health

His Honour Judge Mark LUCRAFT QC

Chief Coroner of England and Wales

Juliet LYON CBE

Chair of the Independent Advisory Panel on Deaths in Custody

Catherine MAY

Equality and Human Rights Commission

Dame Anne OWERS

Chair of the Independent Police Complaints Commission

Dr. Jason PAYNE-JAMES

President of the Faculty of Forensic & Legal Medicine

Libby POTTEN

College of Policing

Alison SAUNDERS CB

Director of Public Prosecutions

His Honour Judge Peter THORNTON QC

Former Chief Coroner of England and Wales

David TUCKER

College of Policing

Professor Peter VANEZIS OBE

Consultant Forensic Pathologist

Professor Ian WALL

Academic Dean, Faculty of Forensic and Legal Medicine

Andrew WARD

Deputy General Secretary, Police Federation of England & Wales

DCI Frankie WESTOBY

Metropolitan Police Central Mental Health Team

Dr Michael WILKS

Registrar, Faculty of Forensic and Legal Medicine

Dame Elish also had meetings with families of people who have died in police custody (see Annex C).

She also held focus groups with:

- The Police Federation of England and Wales
- The Independent Police Complaints Commission
- Coroners
- Inquest Lawyers Group

She also met with representatives from the following community groups and NGOs:

- Institute of Race Relations
- Network for Police Monitoring
- United Friends and Families Campaign
- Defend the Right to Protest
- The London Campaign Against Police and State Violence
- Pan African Social Community Forum

Dame Elish also had meetings with officials from the Home Office, Ministry of Justice and Department of Health.

Annex B:

Public Consultation

Annex B: Public Consultation

An online public consultation was run from 26 February 2016 to 6 May 2016. It attracted over 100 responses from individuals (including serving police officers, healthcare workers, Coroners, academics, and members of the public) and local and national organisations.

In addition to those responses submitted by individuals, formal responses were submitted from the following organisations:

- Criminal Bar Association of England and Wales
- College of Policing
- Crown Prosecution Service
- Epilepsy Action
- Hodge Jones & Allen Solicitors
- Independent Custody Visiting Association
- Independent Police Complaints Commission
- INQUEST
- Inquest Lawyers Group
- Met Detention, Metropolitan Police Service
- North Yorkshire Police
- National Appropriate Adult Network
- National Association of Psychiatric Intensive Care and Low Secure Units
- NHS Providers
- Niche Patient Safety Ltd
- National Police Chief Council Mental Health and Policing Lead
- Oxehealth
- Police Federation of England and Wales
- Royal College of Nursing
- Royal College of Psychiatrists
- Traveller Movement
- Youth Justice Board

Annex C:

INQUEST report of the
Family Listening Days

Annex C: INQUEST report of the Family Listening Days

Introduction

INQUEST were invited to hold two family listening days (FLD) to gather evidence to inform the review.

The events took place over two days (26th and 29th of February 2016) and involved family members whose relatives died in police custody. The event on the 26th was for those who had been through the investigation and inquest, and the second event for those still awaiting the inquest.

The structure of the days saw feedback from families split into two parts; the process and systems that frame the investigation and inquest process, and the emotional, physical and relationship impact during/following a death and subsequent investigation.

Methodology

- The family listening day model is a tried and tested methodology for seeking participant feedback and uses the following framework consistently:
- planned – in conjunction with the review team, families and INQUEST staff
- facilitated – by experienced INQUEST staff, briefed and knowledgeable on the key issues, and with an understanding of the families’ particular cases
- thematic – to provide focus and to avoid the event becoming too wide reaching and broad based
- discursive – by encouraging participants to discuss the issues in a safe and understanding environment, allowing a free flow of ideas and thoughts surrounding the review’s themes
- inclusive – ensuring as wide a range of families affected by the issues under scrutiny felt able to attend and speak
- confidential – information shared during the FLD is honest and heartfelt, and families recognise what is shared within the group should not be used outside the FLD environment. Families are linked by common experiences and should not feel isolated by judgemental attitudes
- compassionate - as an INQUEST caseworker pointed out, “families find it difficult and painful to talk through these things”. The importance of compassion and understanding is crucial to the success of the process

-
- reflective – offering a chance to re-balance power structures and give participants the chance to reflect on the impact of events
 - archived – the families’ contributions are recorded and placed in the public domain

INQUEST has run five of these events in the past for organisations such as the Independent Advisory Panel on deaths in custody, the IPCC, the EHRC and for Lord Toby Harris as part of his Independent Review into Self Inflicted Deaths in Custody of 18-24 year olds.

This report draws out the thematic issues that arose in conversation and uses extensive family quotes to illustrate the evidence and ideas. There are a series of points for consideration, initially included at the end of sections as they arose, and consolidated in the final section of the report.

1. Process

Families discussed the key themes arising from their cases. There was a consensus on key issues and are outlined in this section. These broadly centre around expectations of the process and how initial contacts and communication began to raise doubts about whether these would be met. Families described delays, inconsistent relationships with the investigatory bodies, including Coroners and the variable quality of investigations and reports. Important contributions were made on the relationship between the IPCC and the police and how this has the potential to influence subsequent decision making. Importantly families wanted to discuss the need for information, the need to be equipped to engage with the process, and the vital role legal representation plays in securing successful outcomes.

1.1 Family expectations – what do they want from the process?

No family that experiences bereavement following contact with the police is the same, and every experience is personal and particular to them. If the reaction is unique, the Family Listening Days revealed common threads and families identified commonality within the investigative and inquest process. When asked what they expected of the process there were shared hopes that it would be “independent”, “quick”, “thorough”, “truthful” and that lessons learned would prevent other families having to go through the same thing. It is evident that these expectations were rarely met, although some good practice was apparent. Unfortunately best practice rarely occurred consistently but instead cropped up in an ad hoc way across a range of cases, or worse, in none.

One family member summed up his hopes:

“Fundamentally all I wanted was an investigation that produced something resembling the truth about what happened. And then if there’s any wrongdoing for that to be dealt with promptly and to make sure lessons arrived at through the death are learnt and properly learnt. Six years on and none of those have been delivered yet”.

Another made the point that families have no prior knowledge of investigations following a death and sadly the process resulted in a gradual erosion of belief that it would provide answers:

“Never been through it and I didn’t know what to expect. At some stage you lose that belief you have to start off with”.

Others were quick to call into question the perception of an independent process, describing the emotions of what feels like a struggle for balanced investigations:

“We believed it would be independent, but it was never independent”.

“Independent for who? It was always them against us. It felt like a battle ground between all the parties”.

For others the concept of justice was brought into question. The current system provides little in the way of support for families following a police custody death:

“Prior to this I would have glossed over it, now I’m looking for justice but it’s not always out there”

“The system needs to protect us. It’s up to us to try and prove them wrong. There needs to be a balance”.

For many the biggest hurdle to having their expectations met was the lack of accountability in what felt like a one-sided process:

“What would make the process easier for me is if the police are held accountable, and they show a real desire to change”.

Considerations

- Clearer expectations and guidelines; an explanation of what the process involves, how long it might take, and what to do if you wish to complain about the process.

1.2 Notification of a death

For years families have been telling INQUEST about inconsistencies relating to the notification of deaths in police custody. It has been a recurring theme of previous

Family Listening Days and, as was evidenced at these events, remains a serious issue for families. On reflection many of those who spoke identified it as the point at which their faith or trust in the process began to break down and set the tone for much of what followed. At the heart of the problem appears to be a lack of consistency in the protocols for informing families of the death of a relative, with many explaining the distress at knowing something was wrong, but having no official notification. For some it was a case of delay: “He died on Saturday, we didn’t see anyone from the IPCC until Monday”. In other cases families first information came via the media. There was evidence of officials being in a state of denial, or seeming unsure how to break the news, which was then compounded by promising further support or liaison which

did not arrive. There is also a belief amongst families that those tasked with informing them are not always sensitive or humane when breaking the news of a death as they need to be:

“There was 6 hours before the family members were informed, they said they didn’t have next of kin, his sister rang twice, so they had a point of contact. Two FLOs turned up at 2am, woke the rest of the family and told them, and said someone will be out to see you tomorrow. There has to be a better format for contact with families”.

“My sister had mental health problems and she was detained. Dad and Mum didn’t know. Phoned up at 5pm and kept fobbing my father off, wouldn’t tell him she was there. At 7 or 8 o’clock (they) phoned and the doctor told him she was dead. They said “we will get someone to phone you” but they didn’t. No police came to the house. We were told “you need to go to the hospital”, our dad went but they wouldn’t let him see her, they told him to go home.

One family described a series of events around the notification that pointed towards a lack of sensitivity and empathy:

“I’ve got three children; they came to my house and told me in the doorway downstairs. Two police officers and two IPCC came together. They were not empathetic, they just walked off. My children were left upstairs thinking I’ve been arrested as they took me off to see mum. The Police were in uniform and my daughter phoned me, but they didn’t let me go back upstairs. They told me in the communal doorway, didn’t take me to a separate room. I had to break the news to my mum over the phone. They didn’t care that I had to do that.”

One family member explained her feelings, suggesting it feels like the police are already assessing the family with an eye to the future investigation:

“They see how intelligent you are, trying to belittle you and undermine you. I’m a nurse I know how the system goes. If someone dies, you notify the relatives first thing”.

1.2.1 Finding out about a death via the media

In some cases families found out about the death of their relative via the media:

“Our case was played out in the media. We heard my brother had shot a policeman, and we went from hospital to hospital thinking he was still alive. No police told us till the Thursday. It took three to four days for the IPCC to contact (his) mother”.

One family had unknowingly witnessed attempts to resuscitate their relative on television:

“Our experience was the same – we saw it all on the news. They came to my house 10 hours after he was shot and told us. We saw the resuscitation on the news but didn’t know it was him”.

Another had not been contacted by the police and found out via Facebook:

“On the first day they took me to (relative’s) ex-girlfriend, but she’d found out on Facebook before I got there”.

With hindsight, some families believe the delays gave those involved time to finalise a version of events that projected blame on to the victim, or time to confer prior to the start of the investigation process:

“We heard on the news, after the police had released a story about him being a burglar, and this was before they’d contacted the family. It took them nine hours to come up with their story”.

“He died at 4pm, we were told at 6pm when they came around. There was collusion between the police and IPCC regarding first contact, very intrusive and we felt cornered and interrogated on the same day he died”.

The absence of a national protocol was highlighted by one family:

“The IPCC told us, there’s no timescale by which they have to tell a family of the death. It’s not written anywhere”.

Considerations

- There needs to be a clear protocol for informing families of a death; including by whom, when and a guarantee that all those involved in informing families are skilled communicators trained in dealing with bereavement and grief.
- Every effort must be made to inform families of a death before it becomes public knowledge via the media.

1.3 Information - where to turn for help and advice?

In the immediate aftermath of a death, in a state of shock and confusion, families want advice and information. Some made the point that on first hearing of the death of their relatives, they felt numb and were “unable to take things in”. What became clear is that the earlier they received independent support and advice, the more worthwhile their engagement with the investigation and inquest process was. There was almost universal agreement that without information the whole process was distressing and riddled with confusion and prevarication:

“We were given nothing. It was like a Black hole, you feel like you’ve been swallowed”.

However it is evident this is the norm; information is inconsistently administered, absent or late in being offered. Families, desperate to get answers both about their loved ones and the ‘practicalities’ of what happens next, were offered little by way of advice:

“The following day the IPCC came, they had no information, nothing about what happened to her, why she was even detained”.

“The IPCC didn’t give us any information whatsoever about what had happened. They didn’t give us any information about what would happen. There was no support, no transport”.

“A counsellor told us about INQUEST but it was too late for us. Twenty six (26) months down the line we’d had no advice and support”.

Crucially few families received advice on legal matters, specifically whether a solicitor was required:

“I asked the police “do I need to get a solicitor” and they said “it’s up to you, most families don’t”.

The information vacuum leaves families struggling to make sense of what’s going on and in the absence of state support it’s easy to become isolated and left to become their own investigators:

“Every night, seven nights a week after coming home from work and I had nobody to bounce it off. I was looking on Google because I didn’t understand what things meant. I was very ill equipped for the process, so out of my depth”

1.3.1 Post mortems and viewing the body

The lack of information available on the matter of post mortems causes heartache and anger but also establishes a pattern of mistrust and suspicion around neutrality. Families have the legal right to attend the post mortem, and if they are unhappy with the process or the results are inconclusive, request a second one. According to INQUEST in contentious deaths there can be multiple post-mortems. The initial findings from post mortems can have a significant impact on any subsequent investigation and getting it right from the outset is vital. As one family explained:

“The investigation is always informed by the initial post mortem report. Misconceptions about his position in the van were given to the pathologist as factual evidence and affected the conclusion. The state employs the police and the pathologist. I’m not suggesting that the pathologist was unethical, but (families) need a neutral pathologist”.

Others described being unaware the post mortem had even taken place:

“We were not told about the first post-mortem. They took his brain for investigation. Miscommunication led to a two week delay. We were not told about the second post-mortem and the Coroner’s officer didn’t know either”.

“You can be at a post-mortem, so why have a process where it’s done behind your back?”

In some cases this initial indignity was compounded by a refusal to allow families to see the body of their relative:

“(They) did the post-mortem before we identified the body. We had to wait 24 hours before they even let us see the body”.

“I was never told when the post-mortem took place. I know there was possibly more than one, but not confirmed. I was not allowed to see the body. If they had allowed, it would have been from behind a screen”.

And one family member described the cultural and religious insensitivity of delays:

“What kind of a post-mortem were they arranging between themselves? They knew my husband is Hindu and needs to respect the body; they said “you won’t get it back for another week”. It’s only because we found a Hindu funeral director who knew people and he got the body back in an hour. It’s not the right process”.

Further concern was raised about the way in which post mortem information was delivered to families when contents could be traumatic. It was felt that a letter in the post was inappropriate and where the basis of the report is complex medical information, families were ill equipped to interpret the findings. As one said, “it’s full of jargon”.

“They should not send a post-mortem through the post as the contents are upsetting”.

“It’s difficult even understanding the letters they send you with the autopsy, what samples were taken, you don’t understand it”.

Considerations

- Families should be informed of their rights to attend the post mortem and request further post mortems if required.
- Could post mortems be filmed so the procedure is placed on record?
- Families should receive a copy of all instructions and material sent to a pathologist.
- Families should be given the option of viewing the body of their relative if that is their preference.
- Post mortem reports must include a “translation” in lay person’s term outlining the process and findings.

1.3.2 INQUEST – a source of information

Families were rarely told about the work of INQUEST and were more likely to find about its services on the internet than to have been given details by the police, IPCC or the Coroner’s office. None of the families received the INQUEST leaflet explaining the process, legal requirements or the support on offer following a death. When asked if information on INQUEST would have helped them make sense of the process, there was unanimous positive agreement. One family member identified the crucial information that should be made available to all families at the outset:

“Information should be there – INQUEST, lawyer, pathologist, three things they should tell people, and then you have a fighting chance of getting to the truth”.

Considerations

INQUEST information (leaflet and web details) needs to be made available by the police/IPCC/Coroner's office at the earliest possible time.

1.4 Delays during the investigation

Families' expectations of a prompt and thorough investigation are rarely met. One family described the delays, complications and the anxiety of the wait for resolution as "inhumane for the process to be 8 or 9 years. Why not do it in 18 months?" At a time of crisis families want answers and it was a common complaint that these are very hard to come by. INQUEST has been campaigning on disclosure for years, but delays remain common place. These issues add another layer of uncertainty and suspicion for families, and the negative impact on trust in the justice system should not be underestimated. The emotional impact should also be noted with families framing their concerns in the context of being unable to grieve for their relatives while uncertainty as to what happened remains. The longer the delays, the greater the burden placed on families to "hold things together" as they seek answers to what happened:

"We had lots of questions; we emailed them, and were told we can't give you that at the moment. We were told we can't interview them (the officers involved), they can't give statements. Every time we asked anything it was like a brick wall. After 6 weeks, have you got a response? No. We chased the toxicology for 10 weeks".

"We had an interview with the arresting officer. We gave him questions. We rang him a few weeks later and asked for feedback and he couldn't even remember what the questions were".

"We would raise questions with the IPCC. When they come back we'd ask "have you got the answers" they'd say "no". We made a complaint to the IPCC, because they're not taking our questions seriously. We waited a month and are still no further".

"The police wanted to disclose to us quickly. The IPCC said, "you can't have it", the police said "we did everything we could."

One family found that even the intervention of their lawyer failed to produce results:

"The only response to my questions, for example about copies of videos and custody report, is they should be available as quickly as possible, not ten months down the line. I do have a lawyer now, he wrote to them in December asking them for disclosure, two and a half months after I still have not got it".

1.4.2 Delays in conducting formal interviews and interviewing officers under caution

Chief amongst the concern is the delays in interviewing police officers and other witnesses. Families want officers and witnesses to be interviewed promptly and under caution, as would be the case in any other legal investigation following a death.

“There was five weeks before they made statements, then five weeks for interview and they walked out of interviews. We were told that the delay was because they worked shifts. It’s been too long from beginning to end”.

“(He) was arrested by 3 special constables who were not represented by the police federation, the IPCC left them 6 to 7 weeks before interviews, and they could concoct stories”.

Families are concerned that deaths involving the police are not investigated in the same way as other crimes. Central to this was an apparent disregard for witnesses and witness statements, all the more galling when that applied to family evidence:

“We had a burning need for the truth, not to get the wrong people blamed. As families, we should be given a large benefit of the doubt, not to have our evidence questioned. I recorded what I absolutely remembered and to have it disregarded is absolutely frustrating. Like in the way that rape victims have a lower status, bereaved families are in the same category”.

A member of the same family continued this theme:

“There were 10 civilian witnesses who were dismissed as inconsistent as they were in different places in the street. Because the officers’ accounts were consistent it was accepted that what happened was their version of events”.

There was further frustration at the failure to disclose witness evidence which could have helped them piece together the events that led up to the death of their relative. The gap in information creates a sense of bias:

“It was all one sided, the officers could see what witnesses had said”.

Families wanted to know why officers involved in a death are not more often cautioned prior to interview and felt this could confer greater authority on those conducting the interviews, which in turn would help restore family faith in the independence of the process:

“No interviews were conducted under caution. We had to go to court to order them to restart the investigation”.

Considerations

- Families are entitled to a swift, thorough and independent investigation. Those conducting investigations should provide a schedule, or timeline, of the process.
- If families are unhappy with any part of the process they should be given the opportunity to complain, and to meet with the Commissioner responsible for their area.

1.4.3 Officers conferring

There is a perception that some police officers confer to establish a narrative which protects the action of fellow officers and provides a false picture of the person who has died. Families believe initial statements influence the tone and direction of the investigation and it is difficult to shift the police version of events after “false evidence” is placed in the public domain (see section 1.8 False narratives and victim blaming). This was a common thread from both events.

“We saw on the BBC news police officers with masked faces all standing around. I’ve got pictures on my phone, they’re talking amongst themselves. The IPCC said they could have been talking about anything but they just shot my brother, are they expecting me to believe that they were chatting about the weather? Of course they’re conferring, and you can’t stop them. No body cameras were worn so there is no record of what happened”.

For others it was officer statements that aroused suspicion that the events leading up to the deaths were “managed” or agreed prior to the investigation starting:

“I’ve read 23 police statements, all with the same sentence. Just by reading it you can see its conferring. They thought that they were going to be criticised so they made a plan and everyone was part of the plan”.

Confirming this suspicion one person noted:

“My friend who joined the police told me “if anything happens, we all stick together, we all write the same thing”.

Another simply stated:

“Their statements were very similar”.

One person believes the Police Federation (the officers’ trade union) help orchestrate the process and exerts undue influence over the whole investigation and their role should be examined more closely:

“The Police Federation were there within hours in a room where they (the police officers involved) were conferring. They are very anonymous and always there at the inquest. No-one is questioning their role. One leaned on a police expert, this was subject of a complaint by the family and they had to change the expert”.

Families pointed out that if it’s yet to be established whether it’s a criminal investigation or not there is a risk that evidence could be adjusted.

Considerations

- Officers to be interviewed more consistently under caution.
- Officers must be prevented from conferring where evidence may be adjusted prior to the conclusion of the investigation, or the decision is taken to bring criminal charges.
- Witness statements to be gathered promptly as would be the case in other investigations involving a death.
- Families welcomed the idea of statutory time limits for collecting evidence
- Families welcomed the suggestion of immediate access to legal advice, but stressed the need for it to be independent.

1.4.4 Denial or delays in accessing CCTV footage

CCTV footage can often play a key part in the investigation process and families resent the way in which access to footage is either denied or delayed. There is an argument, often forwarded by police and IPCC investigators that viewing the immediate circumstances of a death can be upsetting and have used this argument when families request access to the pictures. Families at both events reject this and fundamentally believe they have a right to view any CCTV evidence. It is consistent with families' desire to understand what happened, to see how their relatives died, however traumatic.

In keeping with other failures to disclose information, families view it as a tactic to cover up or hide vital facts and it does nothing to engender trust.

Initial difficulties include a denial on the basis of on-going criminal proceedings:

"We asked when we can see the CCTV, when we can see what the officers have said, we were told you can't, there's a criminal process".

For others it was the length of time before they were able to view the footage:

"We had to fight to see the CCTV, they were keeping a bit of it back, and they didn't want us to see. They kept back the filth that came out of the officers' mouth, which they didn't want us to see. The IPCC person said "we don't like inquests"".

"Six months after we got the CCTV, it should have been a week. They'd (IPCC investigators) viewed a bit but were not going to let us know".

"We saw footage which we were lucky to have; the coroner gave it to us. It contradicted everything they said. The IPCC didn't want us to watch it. They didn't know we had it. They wanted to edit it and advised the family to watch edited version".

Transcripts were also denied families on the basis of it being evidence in an on-going investigation:

“We had been told throughout by the IPCC who said “it’s inaudible”. CPS said they had a transcript but they can’t give it to us as its part of the investigation”.

Families are angry that potential evidence of wrong doing, and therefore a potential answer to questions of ‘what happened’ are denied them. Families felt they had to become their own investigators in an effort to guarantee evidence they regarded as vital being included for the purposes of the investigation and report. Aside from wanting legal answers, families want to know what happened as part of the grieving process:

“Initially we wanted CCTV at the police station. He only had 17 minutes of contact with the police from their arrival at the house, and in that time he was dead. As a family you have a million questions running through your mind: its 17 minutes to go from fighting fit and healthy to being dead”.

“We got a specialist to look at the CCTV and evidence of whether her life could have been saved. In that time frame she could have still been alive. We paid for the expert, not the coroner. The coroner focused on another time-frame and totally ignored how the police treated her”.

Considerations

- Develop national, consistent protocols for accessing CCTV footage and ensuring proper working CCTV and audio equipment, to avoid future problems of evidence being held back, unavailable or designated not relevant.
- Families who wish to see the footage from CCTV should be given full disclosure of video evidence (that is without delay when requested).
- Transcripts should be routinely required as part of an investigation and made available to families.

1.5 A lack of empathy

A common thread from the events was the lack of empathy families experienced. Where there were empathetic relationships, these stood out as exceptions rather than the norm. The negative experiences were across the board; from initial contact with the police, Family Liaison Officers (for those that had them), IPCC investigators, and in much rarer cases, Coroners themselves. Families suggest they want to develop good relationships with their points of contact during the process but feel a basic lack of empathy, humanity and defensiveness is a barrier to useful engagement and successful outcomes for investigations and inquests. Of the police families observed:

“Need more empathy towards families. I know it’s a job they’ve got to do, but they chose to do it, families are shell shocked and reeling from what happened. Not sympathetic at all”.

“There was no empathy for how we were feeling”.

Similarly the IPCC were criticised for failing to act in a way that suggested empathy or humanity towards people who are grieving:

“They don’t come across as being there for you”.

“The IPCC were defensive from the moment they stepped into the room with us. It was a battle with the IPCC from start to finish”.

One family had to engage with their initial interview using the telephone, rather than in person, and in an environment that felt supportive:

“I asked to meet the IPCC. She said “can we do it over the phone, we live a long way from you?”. So after two days I’d lost faith. On the Sunday I asked them to come as there was a list of questions the family wanted me to ask, she wouldn’t come to meet me face to face. We had to sit there with a conference call”.

Considerations

- IPCC investigators are trained in dealing with bereavement.
- IPCC investigators are able to develop relationships with families without judgement, and using skills of empathy, understanding and compassion.

1.6 The IPCC – reflections on independence and relationship with the police

Families recognise the difficulties of conducting investigation but want the process to be independent. Many feel this desire is compromised by the close relationship shared by IPCC investigators and those they are investigating. There is a perception that the IPCC operate with the police to protect officers, that investigators tend to be made up of ex-officers who are working with ex-colleagues and this leaves process feeling one sided or lacking true independence. A perception that investigations lack independence angers families and they provided evidence of ways in which the police and IPCC seem to work together.

The IPCC acknowledged these concerns in its review from 2014 in which it committed to increasing the diversity of investigators, encouraging the recruitment of investigators from non-police backgrounds and placing restrictions on investigators leading investigations into forces they had previously worked for. However families reported continuing concerns of partiality which has a negative impact on their satisfaction with the process:

“When they first came in, the way they talked, we thought someone’s here to help us, but very quickly you realise, actually no, they’re on the side of the police. We had to get into the police station and get the photographs to show to the inquest. The IPCC should have done that”.

“I didn’t feel the IPCC were biased, but after reading the report there was confirmation of bias, they want to find the police not guilty”.

Some families observed the closeness of the relationship during the investigation and felt this is a betrayal of trust:

“At the pre-inquest hearing, they walk in chatting together, makes you feel they’re hand in hand”.

“Police have been there with the IPCC every time, even the autopsy”.

“At the funeral they wanted a police presence and the IPCC gave them information. The IPCC is independent so why are they giving police private information? They judge you on what you know, and this effects how they work with you. This is wrong as there are vulnerable people out there, and treating them differently”.

Many families viewed the work of the IPCC as an attempt to cover for police mistakes, and as such had an undue negative impact on the investigation:

“The IPCC is a half-way house to monitor the police investigation”.

“The IPCC were on a mission to show the police were not in the wrong”.

Others felt they were attempting to manipulate statements from families:

“I’d been on my own, they wanted to force me to say things about (relative), tried to put words into my mouth as they saw how vulnerable I was”.

“The number of times I pointed things out, that what we were saying was right, was totally ignored. In the report they said it was inconsistent, but it wasn’t, I know it wasn’t. He was telling me what I experienced, it’s outrageous”.

“The IPCC investigator was a brick wall. Witnesses said that the IPCC sat in the living room for hours, tried to tell them what they saw and what they hadn’t seen”.

There was also disquiet at investigators being former police officers and families believe investigators should not have a previous relationship with the police:

“Which ones are ex-police? There’s an element of luck”.

“The IPCC investigator wasn’t real; he was an ex-policeman who was a wall. We couldn’t talk to him, he was there to defend. It felt like he was protecting his job, protecting the Metropolitan Police”.

“An ex-police officer was being both FLO and investigator. He was obnoxious and had no feelings whatsoever, so rude and arrogant. He was talking to dad like he was an idiot. He asked him to leave. He was taken off the investigation”.

“Needs to be someone above the police, it can’t be ex-police officers. I’m not anti-police, one day I might need them, but it has to be someone who has no connection to the police”.

For some the over representation of families whose cases related to a particular force highlights the need for neutral investigatory powers:

“I want to point out that there are three families here from West Yorkshire. What needs to happen is that all these deaths should be taken out of the local police, and there needs to be a specialist national police branch to deal with these cases”.

Considerations

- Less reliance on ex-police officers when recruiting IPCC investigators

1.7 Quality of investigators and final reports

The quality of investigators and final reports was also criticised by families. Whether families had a competent investigator seemed to be a lottery, and information sharing or good communication was inconsistent:

“The first investigator was well meaning, it was one of his first investigation jobs. He was unconsciously incompetent, not experienced enough. It took lawyers to get involved for us to realise how bad it was”.

“The IPCC are such a mixed bag, some were good, but the second half was really bad because of the lead investigator. It’s totally wrong that the lead investigator “owns” the report, so no-one can advise him. It leads it open to mistakes or corruption if they side with the police officers”.

The ability of the IPCC to fully staff investigations with experienced investigators is often a question of resources and was highlighted as a failing by families. In one case a family were told there was simply not enough staff:

“IPCC said they’ve not got resources to do the forensics so they bring in the police”.

Another heard from their investigator that the police are also outsourcing:

“Police forensics are outsourced to private companies so can’t they get them to collect (evidence)?”

1.7.1 Final reports

Families were, in the main, scathing in their response to the final investigation reports. There were accusations of bias, inconsistent findings and a perception that investigators simply massaged facts to find officers involved not responsible or guilty of wrong doing. In addition the problem of delays and inaccuracies were consistent with much of what preceded them:

“The report was a big disappointment, a complete whitewash”.

“It was a lightweight report, dates crossed out three times and he hadn’t noticed”.

The evidence of delays upset families and adds insult to injury and nurturing a sense of justice denied:

“We’ve not got the final report after five years. They promised to do things; we’ve still not got the answers. People are still employed; there are no consequences, no misconduct action. They said “don’t pursue it, as it will cost too much money””.

“Most of them (officers involved) retired after the event, we’re still waiting for justice”.

“The report never came until last year. It was the longest bit of rubbish. It was all in defence of why (relative) was shot. There was no misconduct action. It was self-defence, they feared for officers lives, despite what forensics showed, all the evidence and what witnesses said”.

Even when families felt sections of the report had provided an accurate assessment of what happened, the overall tone and findings failed to provide the lessons that might prevent future deaths:

“There were two sections of the report which were quite robust. But the key issues that led (relative) to die, they got the evidence wrong. They looked at little sections of time, small enough to justify actions, but they’d not looked at the cumulative set of circumstances. Two police officers passed away in the intervening years. We want something that aids, but this feels like an insult and a total waste of time. I’ve had counselling, but the report floored me. It’s such a huge let down”.

Where reports are seen as positive by families, it remains a “hollow victory”:

“I’ve been reading the report at 2 or 3 am, starting work at 6 am, I can tell you the report inside out. I get satisfaction reading it over and over, but there isn’t a day where I don’t cry”.

1.7.2 Positive experiences of IPCC investigations

Some families had a positive experience with investigators, but were keen to establish the “random” nature of who might be in charge of their cases. They did identify the attributes of a positive investigation; good communication, hard work, commitment, independence (i.e. not an ex-police officer) and empathy:

“The great investigator we had was not ex-police.... Tenacity and follow through, ability to work bloody hard, and disclosure. We also had meetings every month”.

“In the second investigation there was lots of momentum, frequent meetings and feedback. Then we had a new investigator, the meetings stopped, and the report was a big disappointment, a complete whitewash”.

“We had a number of investigators, one of them did beautifully but left for maternity leave. She was so on board and the way she communicated was so clear, really analytical thinking and questioning, and her mind was really open, and she transmitted incredible empathy”.

Considerations

- Fully resourced investigations teams with specialist skills to do the job properly.
- IPCC should identify best practice and share across the agency
- Families should have a role in developing the reports, an understanding of their function and a chance to review or question report contents before its finalised.

1.8 False narratives and victim blaming

Families outlined two key ways the media had impacted on their experiences of the process; for some (see above, section 1.2) the first they knew of their relatives' death was via media outlets (including on Twitter), and others had complaints about the way the media was used by both the police and the IPCC immediately following a death. Families were unhappy that stories, often un-checked by them prior to release, ended up misinforming or "muddying the waters". This took the form of creating false narratives thus helping erode any confidence in the veracity of the investigation and inquest process. Some families felt this was an intentional tactic (often starting at the point at which officers conferred see section 1.4.3) employed with the express purpose of deflecting blame or responsibility away from those involved with the death and shifting it onto the victims. Evidently this "tactic" is not rare as a number of families provided examples where information about the families or their relatives was used to create a false narrative, and according to families, often in collusion with the media:

"They said information was given that (relative) was a drug addict, but that's not true, she had mental health problems. There was an article in the press saying she was a drug addict and the reporter said the information was from the IPCC".

"Within hours the police wrote a statement and read it out in the Mosque that (relative) died in a drugs raid".

"In the media my brother's name was being linked to riots".

"We were presented like a criminal family. How did we become this? A police car was parked outside our house; we felt we were being watched. Our whole lives changed, we had to be careful what we texted on the phone. During the actual case there was a van outside continuously"

"Police came to the hospital at 3am to take a statement but we refused. They wanted details, we said "why are you asking for this information, it's irrelevant", they were trying to paint a bad picture".

One family explained that they knew they were being portrayed in a negative light and it damaged their hopes for the investigation; simply an apology for wrongdoing:

“They are trying to criminalise your loved one, trying to paint you as being a bad character. They’re trying to discourage you by painting a case that is never against the police, but is against you. No-one wants to say “we are wrong”. If that happened then families would be satisfied as accidents do happen”.

The negative portrayal of relatives and their families appears to be a common occurrence and does nothing to facilitate trust from families or indeed the wider community. Whilst this continues mistrust in state institutions and agencies will continue. Families want to be seen as victims of a crime.

1.9 Mental health

Another area of particular concern for those present at the events was the treatment of people who were experiencing poor mental health at the point at which they were in contact with the police. Families shared concerns at the way officers treated people who were ill; the absence of training in dealing with their relatives, the immediate recourse to police custody rather than A and E, a reliance on restraint rather than de-escalation when dealing with people in mental health crisis and failures in assessment and monitoring whilst in custody. Ultimately families were describing a lack of care in repeated cases.

Experiences of poor training and a lack of experienced responders were outlined:

“All those who dealt with my son were not trained police; they were PCSOs, or “specials”. Her excuse was that she only had six weeks training. If you are put out on the street you have to be able to do the job”.

“People don’t understand mental health and become scared. You have to improve the police force so they can understand, like they do for social workers. You can’t learn some things as you can face to face, it’s scary if people are acting erratically”.

Current de-escalation techniques were questioned:

“The lead investigator decided that the officer had de-escalated as it was 56 seconds from his arrival to (relative) being on the ground. Is that de-escalation”?

It was pointed out that other professions had managed to adapt their working practice to avoid the need for restraint and de-escalated the situation instead:

“They need to learn how to work with people with mental health. In the NHS and in schools, other professional’s work, the last thing you do is put your hands on. With the police the first thing is to put hands on”.

Another person highlighted the problem of using out-dated techniques and the need to share best and emerging practice:

“Most forces are still using a restraint video that’s been withdrawn, Marcia Rigg (whose brother Sean died in police custody) knew and they didn’t. Each police force is different, there is no standardised training, and they all do their own little thing”.

Families felt that without specialist, trained responders the default position is to take people into custody rather than to a place of safety with medical expertise. One, who works in the field of mental health, explained:

“There was a mental health problem. If I had a toothache, I wouldn’t go to a shopkeeper, they’re not trained. A person with mental health can act very bizarrely, even for me, but they’re expected to treat them. They shouldn’t be taken to a Police Station”.

The benefits of using A and E and the impact of learning from a notable death in the West Midlands was referenced:

“A person with mental health crisis is a medical emergency and should go to A&E. This would have saved countless people, why can’t they learn it. Section 136 in West Midlands is quite good, which is down to the response after the Micky Powell case and shows follow up can be valuable”.

Another family with personal experience agreed:

“Five years before (the relative) had a psychiatric episode and they did it right, took him to hospital and he came back alive”.

However, where people were taken to police stations there was evidence of poor monitoring and assessment

“There was a lack of any assessment (the relative) was vulnerable and they knew he was a self-harm risk and they knew he was going through bankruptcy. They had a duty of care, but just let him go. The mental health assessment at the end was just a tick list”.

Another family outlined their case in which their relative was taken to a police station but was not monitored whilst in his cell. The officer involved was found to have been watching pornography instead of checking the video feed from the detention cell resulting in the death. In this case recommendations were made at the inquest:

“When someone comes into custody they need to be monitored on camera, but if they’re not near to the custody suite that doesn’t happen. The coroner made a recommendation for a monitor to be away from the custody desk and report to the custody officer if any changes”.

1.9.1 The use of restraint

Where restraint had been used families provided harrowing accounts of the events leading up to the death of their relatives. There was unanimous agreement that the recourse to restraint in medical emergencies was inappropriate and wrong. By using de-escalation techniques these deaths are avoidable:

“We heard how 7 police officers held her down in a cell and stripped her. She was 5”2. There were 4 male officers and 3 women officers. She was restrained in leg restraints like an animal. It was never mentioned to the jury how she was treated. They struggled 15 minutes to get the clothes off her and just left her there”.

The use of force was also described by another family, who also believe that inherent racism plays a part in the police’s decision making processes:

“Our son was restrained by 13 police men and women in a psychiatric hospital and police told the doctor to get out of the room. The doctor heard him say “I can’t breathe”. They didn’t tell us this. Another police force in the morning had been fantastic with him at the Maudsley Hospital. Police and staff worked together, laughing and talking with him. Why couldn’t the evening crew do the same?”

They went on to explain:

“Sometimes the police are bully boys. They see young Black men as “superman”. My son was a big boy, tall and a boxer. They cannot cope as their mentality is “big Black superman”.

Families offered alternative strategies for addressing issues of race and mental health. At the core of these is diversity:

“In Toronto they have different policing – specialist mental health workers alongside police crews. They reduce police deaths and add specialist expertise. It gives police on the job training, they see and understand the issues, so even if they arrest someone for a criminal offence they deal with the mental health first. Also Toronto police force is hugely diverse”.

“Twenty to twenty five years ago there were a lot of Black mental health deaths. Animation was interpreted as aggression. Employing Black people to look after Black people has worked”.

Another suggested medical support to work alongside officers called to incidents:

“Having a nurse specially trained on the scene is a possibility”.

Ultimately there is a need for the police to implement actions that could improve the care of those in custody:

“It’s important to have police forces take on board the recommendations and let families know this is happening, not just forgotten about”.

Considerations

- Police officers to receive specific mental health training
- Police officers are trained in de-escalation techniques.
- Officers responding to incidents involving mental health are accompanied by trained medical staff.
- Those experiencing a mental health crisis are taken to a hospital rather than into custody.

1.10 The role of the Coroners

Of all the state agencies encountered by families it was Coroners and their officers who received the most positive feedback. Families were keen to recognise the role they played in explaining what the investigation and inquest was about, offering legal support and crucially, acting in ways that exhibited empathy, humanity and remorse for what had happened. (It should be noted that families will rarely have direct telephone contact with Coroners and reference to Coroners in the quotes below are more likely to relate to Coroner's Officers).

"The Coroner was great and his associate told me more than the IPCC, I would speak to her daily, but it's not her job, should be someone else. After the first post-mortem or the second post-mortem, the Coroner's assistant rang to tell us that the initial findings were inconclusive; she came to our house and explained".

"The Coroner was very helpful. The day after we were helpless, how can we get help, where do we start? The Coroner told us the questions we needed to ask".

"She was fantastic. First person who said "I'm so sorry". She was the first person who made a link with us".

However the praise for Coroners was not universal, with questions over partiality and experience raised by families:

"The Coroner was okay. He did stop when things were getting bad (during what the family described as very aggressive questioning by the police barrister), but he seemed to be on the side of the police".

"A friend said to me you need to get a second post-mortem, it has to go through the Coroner. The Coroner brought us in for a second meeting, not a very pleasant experience, fortunately he's retired. He said "why do you want another post-mortem" I said, "I want to know the truth", he said, "It's very costly, you won't understand it". This to a mother who has just lost a son"

"You need Coroners who are specialists. He had to go to another Coroner for advice".

Considerations

- Coroners hearing cases involving deaths in police custody need to be experienced.

1.11 Legal representation – ‘equality of arms’

Legal representation is something families felt strongly about and the “inequality of arms” is a strong symbol of how the current investigation and inquest system fails to serve family needs. Families reported that they are rarely told about their rights, or are misinformed about the need for legal representation. Cases involving deaths following contact with state agents are complex and are impossible to manage without specialist legal input. However this knowledge is not shared with families unless they access advice at the very start of the process. In the worst cases some families were told they didn’t need legal representation at all:

“We were told by the police we didn’t need anything. We’ve still not got one”.

“They say you don’t really need a solicitor, you believe what they tell you”.

“I asked the police “do I need to get a solicitor” and they said “it’s up to you, most families don’t””.

“She (the IPCC investigator) said she had never had a case where there was a solicitor, but this was high profile, shouldn’t she have dealt with such a case before?”

Others made the point that solicitors need specialist inquest knowledge and INQUEST have its INQUEST Lawyers Group to refer to:

“You’ve got to have an expert. INQUEST said you can’t just go to someone in the high street, it’s got to be a specialist, we were advised by INQUEST about where to go”.

“I really struggled, rang lots of solicitors up and down the country and couldn’t get a solicitor. If it wasn’t for INQUEST getting me a direct access barrister, I wouldn’t have anyone”.

“That’s why you need an independent solicitor who believes in justice and understands you and knows how it works. So you feel you’re not alone”.

The importance of legal representation is made all the more relevant when families got to the inquest. They described the ranks of multi-party lawyers representing all the state bodies involved:

“The custody officer had a barrister, there was a police barrister and a doctor had his own solicitor. The police barristers worked together to block any questions”.

“The Force and the officers each had a barrister”.

“There were six or eight barristers in our case”.

The difficulties of attending the inquest un-represented were outlined by one person:

“We had to do everything ourselves. We had no lawyer at the inquest. Those three weeks were the most terrifying thing I’ve ever done in my life. I had to cross examine witnesses, it was absolutely terrifying, and they had lawyers. There needs to be a level playing field; a family member should never be put through that”.

However, families face a further obstacle to obtaining legal representation and that’s cost. There is no legal aid for inquests other than in exceptional circumstances and families face an intrusive and complex and mechanism for securing funding. For some this proved to be a step too far, and in the midst of grief and heartache opted not to engage with the applications. Families explained the difficulties they encountered and the inherent inequality in a system that has the tax-payer cover legal costs for state agencies but places a punitive income threshold on families seeking justice:

“Costs were discussed and we were asked to pay £8000 for legal aid. We had to fill in forms to declare savings. R didn’t declare a bank account, it was very invasive but R said “I’m not telling them about money we worked hard for. We got the MP involved, he was brilliant. He talked about it in parliament. Why should I pay to hear what’s been done to our son?”

“They delved into our private lives. We felt we were being investigated, but we are the victims here”.

Another person agreed:

“We didn’t qualify for legal aid. Exceptional funding was refused three times. The MP got involved. We finally got it and we had to pay £5000. The costs would have been £50k-£60k even at legal aid rates. I feel incredibly strongly that legal aid must be given automatically as a right, not means tested”.

For many it is a matter of justice and equality, and families feel this is denied:

“Funding should be available across the board and no issue about income streams. State bodies have the best legal representatives money can buy. I can sell my house, but I’d rather not be in this position after everything else I’ve been through”.

“It doesn’t matter who you are, you deserve justice. Money should not be involved because it’s not your own choice to have the process”.

It was agreed by the group that if the state provided funding it would demonstrate a commitment to reducing police deaths and put an end to the current “abusive” approach to supporting families through the investigation and inquest:

“If the state seriously wants the police to stop killing people, it’s crucial we are organised and given funded expert legal advice from the word go. INQUEST has the right sort of lawyers. Nothing can prepare you for it, you need someone to advise you on the process from the start. What we’re having is inadvertent abuse”.

Considerations

- Non means tested legal aid for families from the outset.
- A requirement to inform families of their legal rights from the outset.

2. Emotional, physical and relationship toll on families

The emotional toll on families is huge and the fact the process can take months and in exceptional cases years prolongs the impact of grief. Families described the dreadful burden of grief, of having to support other family members and the current shortage of professional services. This was felt most acutely for those supporting children and grandchildren.

It was common for families to describe putting grief on hold until they had been through the investigation, inquest or felt questions had been answered; one person put it simply:

“The ability to grieve is postponed”.

Another agreed, highlighting the anguish of surviving a protracted process:

“Losing a child is very difficult as parents. He had mental health issues which took up a lot of emotional time and energy. For the last five to six years it feels like we are looking after him while he is dead. I feel numb and sad. I won’t really grieve properly until this process is finished. It is inhumane for the process to be 8 or 9 years. Why not do it in 18 months”?

Another described the all-consuming nature of the process:

“It (the investigation process) completely interfered with the ability to grieve. It consumed me, it’s my life”.

Another person described the sense of hopelessness felt during the emotional fall out following a death:

“It is like you are punching a great wall and you can’t see what’s behind it”.

One person described what it’s like to live with grief and trauma, whilst trying to negotiate the legal system:

“Over five or six years, all the meetings we’ve had, three investigations, met the Home Secretary three times, can’t imagine how many days I’ve had to take off work. A day or two before hand I can’t sleep and I can’t eat. I have to psych myself up and afterwards I’m completely exhausted the next day. It takes me three days to get over it. Then the trauma of remembering everything”.

If delays and uncertainties place barriers to grieving there are further hurdles for families to overcome and these too seem to be embedded into a systemic culture of neglecting families’ needs. They were left to question the absence of support, the waiting time for NHS services such as counselling, the difficulties of supporting children and grandchildren. There is a ripple

effect drawing in parents, grandparents, aunts, uncles and children; whole families are left devastated and this can lead to relationship difficulties. In the meantime families are seeking answers to what happened to their relative whilst mourning a loss of life. One person summed it up:

“It’s coming up to five and a half years. The toll, the strain, arguments, if I don’t have a reason, I don’t get out of bed.”

2.1 Lack of support

Families compared their experiences, as victims of “state crime”, with other victims of crime and how their support network is different. They felt there was a clear deficit of support on offer and that the nature of the deaths meant employers, schools, counsellors, even friends found it difficult to respond. In order to access services families are confronted by perceptions of stigma and judgement, and there remain serious questions about the inconsistent provision of support services. One of the services afforded other victims of crime is provided by Victim Support and families were unanimous in their belief that:

“Victim Support should be extended to families”.

Others made the point that:

“Murder victims are provided with counselling”.

Once a referral has been made to Victim Support there are chances that state funded support is made available, which is not the case for families affected by police deaths. Accessing services can be both costly and reliant on the ability to find them in the first place. In other situations referrals may be made by employers or, in the case of children, schools. However where there is misunderstanding or uncertainty about the circumstances of a death this may not happen:

“The school didn’t understand what was going on. His wife didn’t speak much English, which affects accessing services and benefits”.

The importance of family support is obvious, but it places a strain on relationships. Families described the difficulties of processing grief and bereavement in the context of a police death and it appears stigma plays a huge part in accessing informal support from outside the family unit. Explaining things at work is difficult:

“I can’t fall apart as people are relying on me. It’s very difficult for me as I have nobody to talk to. At work they all thought I was on holiday”.

Another agreed:

“It’s harder when it’s in public. I work in the NHS and it was splashed all over the paper, they all knew at work”.

There was evidence of the strains placed on families as they tried to provide mutual family support:

“We were married 32 years, the number of times we could have walked out, the strain, there was no-one to talk to. There were different questions within the family, Dad was like a skeleton. In the inquest he wanted to vomit due to presence of police in the room. Five years later I still see the impact. We had to shoulder all of it. I felt let down by everybody – the police, CPS, IPCC, the misconduct hearing. They should have been able to come with some comfort. We still have the same questions”.

“I read something and my husband punched the door. I can’t talk about it for five months every night. He said “it’s got to stop, they have got to be made accountable”.

2.2 Counselling

A few families had used counselling services, and for some this has helped a great deal. There are problems with provision of these services and waiting times and there are acute shortages within the NHS. For those who’d used it the results were positive:

“I got counselling through the doctor, bits of it helped me, the death was only last June. Some days I’m in a state of shock”.

“Without the counselling I’d be a bit of mess. I’m always 5 minutes away from ranting”.

Coping strategies were discussed:

“Afterwards in counselling, she said speak to someone impartial, not one person said this prior to this. Murder victims are provided with counselling”.

“I was lucky enough to get counselling. I was sceptical at first. The inquest is so exhausting, the only way to move forward is to find a balance and counselling is a way to get a plan, a method of dealing with it”.

“I said to the counsellor, “I can’t ever work again” and she said, “you’re doing it for (her son)”. She made me feel better that I can do stuff”.

For others it still felt too soon, or they’d been put off by the potential cost and waiting times in their area:

“I’m already exhausted by the IPCC, I don’t have energy to talk to another person, maybe in future years”.

“I’ve never seen someone to talk to, it’s been recommended but now I would have to pay for it because of the cuts”.

One person was able to pay for the services, but this is not an option for everyone:

“I did have counselling and it worked for me, it was extremely valuable. I know psychotherapists and I paid for it myself and got discounts”.

2.3 Supporting children

If the gaps in provision make it difficult for adults seeking support, the situation is even bleaker for children. Those who have children and grandchildren already face challenges in helping them understand what the death of a relative means, and when there is “gossip” and information on social media surrounding such cases, the need for child centred services is even more pressing. Those who had experience were keen to highlight some of the challenges they face. One person explained that although she is a social worker and is used to working with children, she finds it really hard to support her 3 year old daughter who is struggling.

“It is difficult when it is your own child. It is difficult to access help. CAMS is not helpful in our area, as she does not meet the criteria”.

One mother tried to access support for her 5 year old child but she had to wait 24 weeks for it. She was eventually offered 7 sessions but that came to an end and further support required another referral.

Another described the difficulty of protecting children from the cause of death:

“What do you say to people when it’s in the press? I told his daughter he had an accident and then she saw it on the internet”.

The impact on children is often overlooked by professionals linked to the investigation and inquest process, and families observe the ramifications, both in the short and long term:

“It broke my heart when my grandchild said that he wanted to join his uncle. There is very little support out there”.

“The children is the hardest part. (His) three year old daughter said “daddy’s on his own, I have to go with him”. I have to stay strong for the children, put up a front. I support my 11 year old daughter, I can’t cry with her.

“The children are on a downward spiral, they can’t understand the system”.

“The children 5, 8 and 11, they’ve now grown up 8 years on, and they’re well aware of what happened and need support”.

“As they are growing up, it’s an issue, problems with behaviour at school and at home. They were included at meetings and attended the inquest; the impact on the children is that they’re beginning to grieve now, they need specialist counselling”.

One person highlighted the need professional support, recognising its importance for the wider family unit

“My daughter is two and a half, how can I be a mother to her if I’m depressed all the time. I don’t want her to grow up with that. I got counselling through the doctor, bits of it helped me, the death was only last June. Some days I’m in a state of shock”.

Considerations

- Families should be given information on and funding for counselling and professional support at the earliest opportunity. These interventions are often only considered at the conclusion of the process when evidence suggests early interventions can be beneficial
- Families need to contact INQUEST for support on contacting employers and schools

3. Justice – what does it mean to families?

During the course of both events families had the opportunity to discuss changes that might encourage a culture shift and a reduction in deaths in police custody. Families re-iterated their wish that others never had to go through what they had, but it was also evident that notions of justice were rooted in the negative experiences of the inquests and what happens subsequently; misconduct hearings, failure to take action on recommendations made by Coroners, the failure to prosecute and the slow pace of change.

The experiences of inquest were described in terms of “bullying”, a “missed opportunity” and as “terrifying”. One person described her experience:

“I was treated very badly. I was a witness and the police barrister had me on the stand for three and a half hours. He battered me literally with questions. He accused me of not caring about my son, he was shouting at me, slamming books, was so aggressive. The coroner did nothing for a long time, he was asking very offensive questions and only after three and a half hours the coroner said “okay that’s enough now”.

It was pointed out:

“An inquest is supposed to be inquisitorial, which is meant to be about the truth, not adversarial, I was incredulous at the time that the police could adopt such tactics in the inquest situation”.

Families were confused and angered by misconduct hearings and the lack of meaningful action taken by police forces after officers had been found guilty of misconduct:

“Police have admitted wrong doing, and have decided the fate of the officer. I struggle with the IPCC allowing the police to manage the case themselves. They allow the police to decide what happens to the officer. They said as it’s the first time it’s happened, he will get a slap on the wrist. If it happened again he would get a disciplinary. If it happened at any other organisations there would be criminal proceedings”.

“Officers are still keeping their jobs. They are not being suspended or their duties limited whilst the investigations are taking place. Families are not informed but most believe that it will be nothing more than a “slap on the wrist”. They also try to retire to avoid action. They know that they can get away with it”.

“There will be no change until the Police are convicted of crimes, brought to account for gross misconduct, lose their jobs. In any other job that would happen. They need to know “if we don’t do our jobs properly, this is what’s going to happen”. Until they are brought to trial, I don’t think they will do”.

“You hope they will give you the justice you are searching for. The officer found guilty of gross misconduct got a written warning because he was an exemplary officer with 22 years’ service”.

Families felt the police were hypocritical on the subject of taking responsibility for wrongdoing:

“It was in the news a few weeks ago, when a civilian was convicted of murder or manslaughter, and the inspector said “one stupid punch can kill someone, people have to take responsibility for their actions”. But if police do it, it’s okay”.

There is also dissatisfaction at the failure to change the culture of policing and families believe there is little or no accountability:

“The police need to be accountable, there needs to be a desire to change in the police and there is none. They’re not punished when they’ve done something wrong. You can’t prove they’ve done something wrong, the whole machine is geared to crunching out a “no-fault widget”. There is never a level playing field. How can you get justice in a system geared toward finding no one at fault”?

Families welcome examples of where Coroner’s recommendations have been taken on board, and it chimes with a shared desire to prevent future tragedies. Examples given included:

“They changed the size of vans, the cages are a different size and have cameras in, we saw the new vans, they were two feet square before”.

“They should now have defibrillators at police stations”.

“Learning about not doing spy hole checks, they now need to open the hatch. Bootham Hospital has reopened a place of safety, they had closed it and in January 2016 it was reopened”.

“Recommendations for drug searches and mouth searches came out, also that the scene of death is a scene of crime and should be kept sterile”.

However much families welcome changes there is still concern that compliance remains sporadic:

“The coroner can write a letter saying you need to change. They will write a letter and five years later it’s no different”.

“Unless the police become accountable, nothing will change, whether they follow recommendations or not. There has to be some means of enforcing change, they’ve got to follow the recommendations”.

For all the discussion around systemic changes there is a clear evidence for a more personal response to grieving families and saying sorry is central to this. Families are struck by how rarely anyone said sorry or apologised for their actions. When it does happen it's welcomed:

"We appreciate them saying sorry, it's about admitting, some person high up saying "we're very sorry".

"After the misconduct proceedings we had a one to one with the Chief Constable, the Police and Crime Commissioner and the family. He did apologise to all of us "we're really, really sorry and we got it wrong".

The cultural implications were compared to another high pressure profession:

"With airline pilots they're told "you won't face prosecution if you admit a mistake early on". They don't try to cover it up, it is an incentive in the system to own up".

The rationale for wanting someone to apologise is simple:

"You want to feel that they actually care what's happened".

The need for change is vital because "at the moment no-one is getting justice" and what's needed was summed up thus:

"If there is not one successful prosecution it's a deeply dysfunctional system. I'm really glad Theresa May is doing this review, cultural change is needed. I've seen that the IPCC is trying to reform, its leaders are well intentioned, but they're not there yet. Please can we actually see some action to reduce deaths, follow through is incredibly important. I would have to say to the Chief Constable "what are you doing about policing of mental health". Higher up the food chain you need the will to create a culture change. The Chief Constable should be in the firing line for reckless stupidity of the people he employs".

Considerations

- Clearer expectations and guidelines; an explanation of what the process involves, how long it might take, and what to do if you wish to complain about the process.
- There needs to be a clear protocol for informing families of a death; including by whom, when and a guarantees that all those involved in informing families are skilled communicators trained in dealing with bereavement and grief.
- Every effort must be made to inform families of a death before it becomes public knowledge via the media.
- Families should be informed of their rights to attend the post mortem and request further post mortems if required.
- Could post mortems be filmed so the procedure is placed on record?

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- Families should receive a copy of all instructions and material sent to a pathologist.
 - Families should be given the option of viewing the body of their relative if that is their preference.
 - Post mortem reports must include a “translation” in lay person’s term outlining the process and findings.
 - INQUEST information (leaflet and web details) needs to be made available by the police/IPCC/Coroner’s office at the earliest possible time.
 - Families are entitled to a swift, thorough and independent investigation. Those conducting investigations should provide a schedule, or timeline, of the process.
 - If families are unhappy with any part of the process they should be given the opportunity to complain, and to meet with the Commissioner responsible for their area.
 - Officers to be interviewed under caution.
 - Officers must be prevented from conferring where evidence may be adjusted prior to the conclusion of the investigation, or the decision is taken to bring criminal charges.
 - Witness statements to be gathered promptly as would be the case in other investigations involving a death.
 - Families welcomed the idea of statutory time limits for collecting evidence
 - Families welcomed the suggestion of immediate access to legal advice, but stressed the need for it to be independent.
 - Develop national, consistent protocols for accessing CCTV footage and ensuring proper working CCTV and audio equipment, to avoid future problems of evidence being held back, unavailable or designated not relevant.
 - Families who wish to see the footage from CCTV should be given full disclosure of video evidence (that is without delay when requested).
 - Transcripts should be routinely required as part of an investigation and made available to families.
 - IPCC investigators are trained in dealing with bereavement.
 - IPCC investigators are able to develop relationships with families without judgement, and using skills of empathy, understanding and compassion.
 - Less reliance on ex-police officers when recruiting IPCC investigators
 - Fully resourced investigations teams with specialist skills to do the job properly.
 - IPCC should identify best practice and share across the agency
 - Families should have a role in developing the reports, an understanding of their function and a chance to review or question report contents before its finalised.

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- Police officers to receive specific mental health training
 - Police officers are trained in de-escalation techniques.
 - Officers responding to incidents involving mental health are accompanied by trained medical staff.
 - Those experiencing a mental health crisis are taken to a hospital rather than into custody.
 - Coroners hearing cases involving deaths in police custody need to be experienced.
 - Non means tested legal aid for families from the outset.
 - A requirement to inform families of their legal rights from the outset.
 - Families should be given information on and funding for counselling and professional support at the earliest opportunity. These interventions are often only considered at the conclusion of the process when evidence suggests early interventions can be beneficial.

Chris Tully

5/27/2016

The report was written for INQUEST by independent consultant Chris Tully. He assisted in designing the Family Listening Day model. He has helped deliver Listening Day events and written reports arising from the day for the Independent Advisory Panel on Deaths in Custody, the Independent Police Complaints Commission, the Equalities and Human Rights Commission and the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. He designed the INQUEST Skills Toolkit for families and has delivered training for the organisation. He has 27 years experiences of working with voluntary sector organisations and has also conducted monitoring and evaluation projects for Clinks, Women in Prison and INQUEST.


