INQUEST
TRUTH, JUSTICE & ACCOUNTABILITY

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

POLICY • ADVICE • CAMPAIGNS

INQUEST provides specialist advice and a complex casework service to people bereaved by a death in custody/state detention or involving state agents and works on other cases that also engage article 2 of the ECHR and/or raise wider issues of state and corporate accountability. INQUEST's evidence based policy, research and parliamentary work is informed by its casework and we work to ensure that the collective experiences of bereaved people underpin that work. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent future deaths.

INQUEST director, Deborah Coles, was special advisor to the Independent Review of Deaths and Serious Incidents in Custody.

INQUEST also facilitated a family listening day for the Review.

This is the *summary* of our full response to the consultation on the Independent Review of Deaths and Serious Incidents in Custody. The full response is available on request.

Please credit 'INQUEST' when citing this material.

Introduction

"At the crux of the issue is the democratic accountability of the police at an individual and corporate level"

INQUEST's response to this consultation is informed by our specialist casework and associated evidence-based policy and parliamentary work conducted over the last 35 years[1]. It has also been informed by evidence from the Family Listening Days INQUEST held specifically for this Review, and family evidence from previous Listening Days and our Family Forum. It has been families who have fought for justice for their relatives and their campaigns in the public political and legal arena that have led to lasting changes to the investigation and inquest system. That the Review came about at all is the result of the tenacious determination and campaigning of bereaved people.

There has been considerable anguish, anger and frustration about the lack of accountability after deaths in custody and the failure to hold the police to account where there is 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, despite evidence of unlawful or excessive use of force or gross neglect. As the dossier of inquest outcomes highlights, the same issues of concern arise repeatedly. This has been extremely damaging to family and public confidence in the judicial process and frustrates the prevention of abuses of power, ill treatment and misconduct. At the crux of the issue is the democratic accountability of the police at an individual and corporate level.

As the European Committee on the Prevention of Torture has reported:

'The existence of effective mechanisms to tackle police misconduct is an important safeguard against ill-treatment of persons deprived of their liberty. In those cases where evidence of wrongdoing emerges, the imposition of appropriate disciplinary and/or criminal penalties can have a powerful dissuasive effect on police officers who might otherwise be minded to engage in ill-treatment.'

INQUEST has published a range of reports and made submissions on the issues covered by this Review over several decades[2]. There have also been parliamentary inquiries, and reviews by a number of governmental and non-governmental organisations Despite a plethora of recommendations arising from investigations, inquests, inspectorate reports, inquiries and reviews, the same systemic failures and problems are repeated. There is little evidence of institutional or individual learning from these cases.

[1] Many of the cases referred to within our consultation response are at the post-inquest stage and therefore the deaths occurred several years ago. The same issues arise in our current casework but because the investigations are on-going it has not been possible to include many of the more recent examples. We have incorporated the systemic issues arising more broadly in the relevant sections.

[2] A file of relevant INQUEST publications has been provided to the Review

Achieving proper investigations and inquests, never mind achieving robust and meaningful change, involves enormous challenges, frustrations, obstacles often at great personal cost to the emotional and physical health of family members, young and old. Too often their needs have been reduced to the lowest priority by institutions concerned to protect their policies, practices and procedures.

Each section of the consultation response contains a short overview and a list of INQUEST's recommendations, followed by the full response.

We have conducted an historical analysis of three themes in order to identify the extent to which action has been taken in response to deaths over the past decade and a half. These three themes are i) observation regimes for intoxicated detainees, ii) restraint and iii) mental health. For the latter two, we have used the Roger Sylvester inquest, and the initiatives that followed it, as our starting point to review what has come since. We have sought to examine the ways in which this high profile case, which resulted in significant community, political and legal scrutiny, generated numerous recommendations many of which have simply been neglected and ignored. For INQUEST, many of the key concerns raised then are just as applicable today.

Our broad concern is that in some areas there is simply a recurrence of the same problems and the same concerns articulated year after year. In other areas there are positive developments but these are piecemeal, often localised and ad hoc, and often driven by bereaved families and concerned individuals. Too frequently many years pass without identified failings being acted upon, until a particular initiative gives some impetus. Examples of this are training for police on mental health and street triage. We attribute this to the lack of a cohesive national framework for addressing deaths in police custody and monitoring of the investigation and inquest process. We return to this in our reply to questions 14 and 15 of the consultation.

A thread that runs through our replies to the various consultation questions is the need to create a culture within the police that has embedded in it the key concepts of duty of care and the protection of the rights of detainees. The fundamental reason why individuals join the police service is to combat crime, which is reflected in the training received by officers. Police training can result in those in conflict with the law being dismissed or regarded in a hostile manner. This contradicts the need to be aware of, and proactively pursue a duty of care towards detainees, particularly given the vulnerability of many of those who come into contact with the police. This contrast can be seen most strikingly in a significant number of cases where officers have considered those in a critical medical condition to be feigning illness or 'faking it'. It is disturbing how many inquest narrative conclusions and Coroners' reports refer to

this[3]. Although these are stark examples they exemplify an attitude that underlies many other police failings.

Since being formed in 1981 INQUEST has consistently raised concerns about an institutionalised culture within the police service which stigmatises the "undeserving detainee"[4]. We are concerned that the assumptions and values of some staff can guide behaviour within the police station. Police staff, constables and civilian detention officers alike, are socialised into the culture, which informs the treatment of detainees. It is critical that at the heart of the training received by staff is the understanding that detainees are dependent upon them for their basic needs and rights and that they are given the proper resources to carry out their duties so as to meet those needs. This is why independent inspection and monitoring is so important, as within a closed world an unhealthy culture can go unchecked. Coroners have commented on how unacceptable police officer "banter" has detracted from care for detainees in the lead-up to a death, for example offensive, sometimes racist language about detainees and officers looking at sex sites on the internet rather than monitoring in-cell CCTV[5].

We also draw attention to the fact that the common themes that arise in deaths in custody affect a far broader group of detainees. Fatalities are at the sharp end of a continuum from mistreatment through to death. There are a large number of 'near miss' cases which raise identical issues, some of them resulting in serious injuries (see two case studies below). The IPCC published a Report on Near Misses in Metropolitan Police Custody (MPS) in March 2008[6]. This found 121 near misses within the MPS during the period of study which the IPCC extrapolated to approximately 1,000 near miss incidents in police custody nationally per year. Of these approximately 400 were cases where death was very likely or fairly likely. Many of the report's recommendations are the same as those that arise in a great many inquests.

[3] See dossier of inquest outcomes section 10 comments regarding Sean Hardy, Leonard McCourt, Colin Holt, Habib Ullah and section 9 findings regarding Stacie Le Page. This also arose at the death of Christopher Alder in 1998 which led to a manslaughter prosecution

[4] See INQUEST website here: http://inquest.org.uk/pdf/Deaths_of_Black_Minority_and_Ethnic_People_in_Custody_1998.pdf

[5] See section 19 of dossier of inquest conclusions and Coroners' reports regarding Paul Coker and Lloyd Butler, INQUEST is aware of this arising in many other cases where not formally recorded by Coroners

[6] https://www.ipcc.gov.uk/news/ipcc-publishes-report-near-misses-police-custody

The following are two graphic examples of failings resulting in serious injuries which closely reflect those that commonly arise in custody deaths:

> Ms B was arrested in Northumbria for being drunk and disorderly, when in fact she was suffering from a hypoglycaemic attack and in need of hospital treatment. No formal risk assessment was carried out on her arrival at the police station and she was left in a police cell for nearly seven hours without being checked or roused as required by national and local police guidance. When eventually checked she was found to be in a coma. She suffered brain damage and received £450,000 compensation from Northumbria Police.
>
> Ms H was suffering an acute psychotic episode. Police arrested her to prevent a breach of the peace rather than detaining her under section 136 Mental Health Act and taking her to a 'place of safety' in a healthcare setting. She was eventually assessed and remained in police custody waiting for a hospital bed to be found. She self-harmed throughout her detention and 23 hours after her arrest she frenziedly and repeatedly smashed her head against the cell floor, resulting in restraint and immediate hospitalisation. She has required reconstructive surgery for self-inflicted facial injuries.

Furthermore, the issues that are raised in deaths in custody cases have an impact upon the custodial health, safety and welfare of vast numbers of detainees where there is no loss of life or serious injury. For example, the unnecessary use of restraint is deeply degrading and frightening for detainees and a focus on de-escalation techniques can improve policing responses so as to avoid the use of force. Use of police cells as a 'place of safety' for those detained under section 136 Mental Health Act means that detainees experience the harshness of the police station environment at a time of acute vulnerability.

People who spend time in police custody are not generally a group who campaign collectively. Many are extremely marginalised within society, for example they may be repeat offenders or have mental health problems, and there is shame and stigma around having been in police detention. Whilst 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 public debate. Deaths trigger an investigation which shines a light upon the detainee experience and have brought family members into the public arena to campaign. Inquests and other deaths in custody investigations provide the opportunity for a close and critical examination of the closed world of police custody and for civilians to input directly into the process.

Families of those who have died have engaged with this Review in the hope that it will bring about real and sustained cultural and political change. This consultation is an important opportunity that must not be squandered if the scandal around the deaths of some of the most vulnerable individuals in our society is to be avoided in the future.

Question 1: In what ways could the risk of death/serious incidents in police custody be avoided?

Overview

Time and again inquest outcomes record failings in custody procedures which are designed to protect the health and wellbeing of detainees and to address the risks to life in the custody environment. INQUEST has highlighted these recurring issues repeatedly following inquests up and down the country, in its campaigns and policy work and its numerous publications.

The dossier of inquest outcomes prepared by INQUEST for the Independent Review contains narrative conclusions and coroners' reports spanning a decade which repeatedly point to similar failings across different police forces and across time. We refer in particular to sections 4 to 9 of the dossier which summarise custody safety issues under the headings:

- fitness for detention
- risk assessment at the police station
- observation regimes for intoxicated detainees
- communication exchange in the custody environment
- records on police information systems
- medical care within the police station

Lack of implementation of custody safety procedures is the recurring theme within most of the inquest outcomes on the above issues. The key question for families, for INQUEST and for the Independent Review is how and why it is that well known reasons for deaths within police custody are not properly addressed by the mechanisms that exist for learning and implementation.

In order to fully appreciate the repetitive nature of the concerns raised, INQUEST has conducted a historical illustration of one clear group of failings: observation regimes for intoxicated detainees. The lack of progress in addressing this common cause of death is tracked through time, from the 1980s to the present day. We see a lack of joined up working between investigations, inquests, police forces and oversight bodies. The repetition speaks for itself in demonstrating that the oversight mechanisms that currently exist are not delivering.

The key recommendation arising from this analysis is the need for an overriding framework for learning and implementation. Inquest outcomes should feed into a process that enables lessons learned during the inquest to be translated into training, monitoring, implementation and change on the ground. This proposed framework is addressed in our reply to questions 14 and 15 of the consultation.

Question 2: What actions could be taken by the police to avoid or reduce the risk of death/serious incidents following or as a result of police use of force, with particular reference to the use of restraint?

Overview

Deaths involving police restraint continue to be the most controversial and politically charged of all police cases and INQUEST has long campaigned with families around this issue. Many have involved men from black and minority ethnic groups and increasingly these deaths have involved those in mental health crisis. Several have involved the brutal and excessive use of restraint in health care settings.

The death of Roger Sylvester in 1999 led to what was hoped would be wide scale changes around the use of restraint. The dangers around the use of prone restraint became largely established through police guidance and training. Over a decade and a half later deaths continue to occur in circumstances involving the use of prone restraint, particularly of those in mental health crisis. This is deeply concerning, raising serious questions about the failure to develop and sustain learning around this dangerous and controversial police practice. Police at an individual and corporate level are rarely held to account where restraint has been used unnecessarily, disproportionately or excessively.

Equally concerning has been the failure to adjust police practice to reflect increasing and compelling evidence of the life threatening dangers posed by restraining someone in mental health crisis. Narrow training and understanding around prone restraint and positional asphyxia fails to encompass or address these broader dangers and concerns.

The term 'excited delirium' is inappropriately used by some pathologists, coroners and police representatives to refer to a physical condition inevitably leading to death. Attempts continue to explain away the central role that restraint plays in police deaths. There is limited understanding by police officers of the physiological processes associated with restraint during mental health crisis and their links to fatalities. Those in mental health crisis or suffering some form of psychosis are high risk groups as they may not have the same level of insight and may struggle beyond physical limits.

This section should be read in conjunction with Question 4 on mental health.

Recommendations

1. **Police must be held to account either an individual or corporate level** where restraint has been found to have been used in an unnecessary, disproportionate or excessive way.

2. 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 some form of psychosis poses a life threatening risk**.

3. **'Excited delirium' should not be used** as a term which alone explains cause of death.

4. Police practice must move on from the **misconception that only face down restraint can cause death as a result of positional asphyxia**. 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.

5. 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**. It should be used for the very shortest time possible and an ambulance should be called for transportation to A&E (see more under Qu 4 on mental health).

6. A **mandatory safety officer model** should be implemented by all police forces similar to the prison setting, where a lead officer is responsible for oversight (including the monitoring of vital signs) and management of any incident of restraint to ensure safety and compliance with welfare and risk assessment. To ensure implementation, failure to comply with this model should be a serious misconduct matter.

7. **Health care professionals should take primary responsibility for the conduct and safe management of restraint** of patients in any healthcare setting. This should be written into police and NHS policy. This is particularly so in psychiatric settings, where approaches to the use of force are very different to those applied by the police. Prone restraint should not be used by police in any health care setting.

8. A national strategy is needed to develop **consistent and effective restraint training** throughout all forces. This should stress the potential fatal results of inadequate attempts at de-escalation and safe containment. It should highlight the dangerous and escalating impact of restraining someone in mental health crisis (see also

training recommendations at Qu 4 on mental health) and the other recommendations above.

9. **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, including misleading uses of the terms ED and ABD. This should underpin future police training.

10. **The use of restraint equipment** is leading to dangerous and oppressive policing practices and should be more robustly limited and monitored.

11. **CCTV should be introduced in police vans** nationally to allow monitoring of restrained detainees, in conjunction with vigilant supervision of welfare and safety during transportation.

12. **Properly functioning CCTV and audio recording equipment** within police stations should be ensured at all times and failure to maintain it should give rise to consideration of misconduct action.

13. **A mandatory system of recording incidents of restraint** has long been advocated by INQUEST, similar to the system operating for many years in the prison setting. The national 'use of force' data collection (announced by the Home Secretary and due to begin in April 2016) must be 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 must be part of that system.

Question 3: What actions could be taken by the police and other organisations to reduce the risk of self-inflicted deaths within 48 hours of police custody?

Overview

Many of those arrested are highly vulnerable due to pre-existing mental health difficulties and/or face a personal crisis because of the circumstances of the arrest, sometimes for a highly stigmatising crime such as sexual or domestic abuse. The numbers of self-inflicted deaths shortly after release are very high and rising.

Police custody should be treated as an opportunity for positive intervention on behalf of people who have mental health needs and are

potentially suicidal. The concept of a duty of care towards vulnerable individuals beyond their immediate presence within the police station needs to be embedded within police culture.

Real progress has been made in reducing self-inflicted deaths within police stations and the challenge now is to extend protective steps towards those identified as at particular risk beyond release.

Recommendations

1. Liaison and diversion schemes linking those experiencing mental health problems with mental health and other support services should have secure funding and be rolled out nationally

2. The College of Policing APP on detention and custody and force training should include clear guidelines for pre-release risk assessment setting out the steps that should be taken to provide support and protection for those at risk of self-harm on release. These should include practical steps to be taken with the consent of the detainee. The APP on mental health should also address this. Training should place these requirements within the context of the police duty of care towards vulnerable members of the community

3. Medical input should be obtained into the risk assessment process at the point of release

4. Custody inspections should include a 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 and HMIC

Question 4: To what extent is mental health a factor and how do you think this should be addressed?

Overview

INQUEST and the families we work with have been calling for urgent reform for a safer policing response to those in mental health need. The majority of deaths following a mental health crisis have involved apparently physically healthy men in circumstances where there are concerns about the excessive use of force and restraint disproportionate

to the risk posed. INQUEST recognises that mental health is also a critical issue in many other situations within police custody and our dossier of inquest outcomes summarises custody safety issues affecting detainees with mental health needs.

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.

INQUEST has identified common features across cases involving mental health issues:

- **poor police recognition of mental health** and misinterpretation of bizarre and disorientated behaviour;
- **poor de-escalation and communication** leading to unnecessary use of restraint
- insufficient focus on **diversion to mental health systems** in place of arrest
- prioritising perceived **criminal conduct over mental health needs** (even where this conduct derives from a mental health crisis) including arrest rather than detention under Section 136 Mental Health Act (s136)
- **transferring to police stations and not hospital,** particularly use of police stations for detention under s136 in place of health-based 'places of safety'
- **dangerous transportation** in police vehicles rather than ambulances following detention under s136
- **failures/delays engaging emergency health care** (whether to summons an ambulance or transfer to hospital)
- failing to see past **alcohol/drug intoxication** as masking mental health issues
- inappropriate use of **police restraint in mental health settings**

Inconsistent practices and systems: some individual forces operate detailed mental health policies and practices, others rely only on minimum setting national guidance.

Discriminatory fears, assumptions and 'mad, bad and dangerous' stereotyping informing inappropriate and dangerous policing response to those in mental health need, including in the excessive use of force.

Woefully inadequate mental health training which fails to reflect the significance of this issue across a high proportion of police work. The need for such training has been identified by policing bodies for well over a decade yet has not been sufficiently prioritised or resourced.

Recommendations

1. **Proper resourcing of national healthcare facilities/provision** able to accommodate and respond to the growing number of vulnerable people in urgent physical and/or mental health need coming into contact with the police.

2. **New 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, including:

    a. overriding importance of a humane, calm and reassuring approach which focuses on **de-escalation and safe containment**;
    b. the need for an urgent **health and welfare response** not a criminal justice response: avoiding arrest where-ever possible and in other cases prioritising use of s136
    c. recognising the **life threatening risks arising in restraint of someone in mental health crisis (**due to lack of insight and the likelihood of struggling beyond physical limits where the system can become rapidly and fatally overloaded)
    d. priority being **safe transfer to a health care setting**;
    e. **understanding of drugs and/or alcohol** as a dangerous additional feature pointing to the need for emergency medical care

3. **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. **Ending the use of police stations as s136 'places of safety'**. Police guidance should not condone the use of police custody on the grounds that a detainee's behaviour is too difficult to manage in a healthcare setting. Although attempts to reduce use of police cells has reduced numbers these are still far too high and practice is not consistent across forces. This should be achieved through properly resourcing health-based 'places of safety' and improved police guidance and training on use of s136.

5. **Development of clear procedures around the operation of s136** 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.

6. **Ending the use of police vehicles for transporting people in mental health crisis** in any but the most exceptional of situations. These are health emergencies (particularly where force has been used) and an ambulance should be summoned for all s136 detainees.

7. 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 and prone restraint should not be used by police in any health care setting.

8. **Commitment and responsibility at leadership level** is needed across forces to ensure prioritisation of the issue of mental health to bring about sustained urgent cultural, organisational and practical changes. Leadership is needed to counter the sometimes entrenched police view that 'mental health isn't our job'.

9. **Recruitment practices** need to reflect the changing profile of police work. Recruitment processes should incorporate the different personal skills and experiences needed to fulfill duties relating to the needs of highly vulnerable groups.

10. **Successful local mental health policing pilots and initiatives**, particularly street triage and liaison and diversion scheme 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.

Question 5: To what extent is ethnicity a factor, why, and how do you think this should be addressed?

Overview

It is well documented that people from black and minority ethnic (BAME) communities are disproportionately represented in the criminal justice system at every level, from stop and search, arrests, criminalisation,

imprisonment and deaths in custody following the use of force/medical neglect.

The Independent Review needs to have an appreciation of the broader political and social policy context in which controversial police-related deaths occur and the profound impact on police and community relations resulting from a number of high profile BAME deaths and the lack of police accountability at an individual and corporate level.

It is vital for the IPCC to address the issue of racial stereotyping and discrimination. Historically there has been a lack of understanding by the IPCC of broader themes around race, particularly in restraint-related deaths of black men, in part due to a focus on cases in isolation and subsequent failure to address broader patterns. We note that the 2015 IPCC guidelines on discrimination contain a case example which illustrates many of the issues raised within our consultation responses, which should be embedded into IPCC investigations.

The cases in which INQUEST has been involved present a disturbing picture of stereotyped imagery of BAME men in particular, as 'dangerous', 'volatile' and 'exceptionally' strong. This is used to explain police use of force that is greatly disproportionate to the risks posed, including where a single individual is restrained by a group of officers.

Negative imagery also informs the treatment of those with mental health needs – the stereotype of the mentally ill as 'mad, bad and dangerous'. INQUEST is particularly concerned with the double discrimination experienced by black people with mental health issues.

Deaths occur where the focus is entirely upon 'compliance' with a disregard for the welfare and safety of the detainee until they are in a critical medical condition.

There is a lack of rigorous data collection around ethnicity and police use of force so that the available statistics are inadequate.

Recommendations

1. The key issue here is one of accountability. **Police officers must be held to account for account for abuses of power. The failure to do so undermines community confidence in the police and is damaging to police and community relations.**

2. The IPCC should ensure that **race and discrimination issues are considered as an integral part of its work.** This should be monitored and feed into **internal learning and the IPCC's 'watchdog' role.** The IPCC should take a public position on discrimination issues.

3. IPCC investigators should consider how 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.

4. The IPCC should **address discrimination issues robustly within misconduct recommendations,** including where discrimination is not overt but can be inferred. Where police forces refuse to include these within disciplinary action the IPCC should direct the inclusion of disciplinary charges of discriminatory conduct.

5. **National policing bodies and police forces should implement training on 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[7] 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.

6. 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.

7. 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.

8. The IPCC should **monitor the correlation between ethnicity and restraint-related deaths.** The current monitoring between ethnicity and deaths in police custody generally does not provide sufficient focus and also excludes those cases involving police use of force outside of police custody, such as police restraint in mental health detention settings.

9. The IPCC should not monitor ethnicity and deaths in custody against ethnicity and arrests by reference to arrests for **notifiable offences.** Such arrests do not provide a relevant benchmark so that any resulting statistics are not meaningful.

[7] an interesting initiative is the "300 voices project" by West Midlands Police

Question 6: To what extent are drugs/alcohol a factor and how do you think this should be addressed?

Overview

Failures to properly implement observation regimes for intoxicated detainees lie at the heart of numerous deaths in police stations. Inquests have identified failings by custody sergeants, other police officers, civilian detention staff, nursing staff and FMEs. Many custody and nursing staff are employed by private service providers.

Non-compliance with observation regimes has been found to be persistent, widespread, identified repeatedly over time and across numerous police forces (see our response to question 1). There is a lack of focus on this issue within force inspections and the HMIC inspection regime.

Failures are also regularly identified around: mistaking serious medical conditions for intoxication; not recognising that intoxication can mask head injuries or other conditions; dangers associated with reduced consciousness going undetected, including obstruction of the airways; failure to understand that alcohol withdrawal syndrome can be life threatening.

Recommendations

1. **'Drying out centres'** should be established to divert intoxicated people away from police custody and away from accident & emergency departments (unless in need of urgent treatment). When considering the cost effectiveness of such centres the savings to police and NHS budgets should be taken into account. Such centres should have staff trained in the dangers associated with intoxication and on-site medical personnel.

2. HMIC should include a focus on **inspection of observation regimes for intoxicated detainees** within its Expectations of Police Custody (updated April 2016 see our reply to question 1 pages 9 &10). HMIC should monitor police forces' internal inspection procedures for observation regimes.

3. An NHS initiative at the national level is required to implement a prohibition on **refusing access to A&E or to health-based places of safety** under section 136 Mental Health Act (s136) on the basis of intoxication.

4. **Joint local protocols** should be established between police forces, ambulance services and hospitals to cement the right of access to medical care for intoxicated people

5. **Comprehensive and standardised police training** is required across forces for custody sergeants, officers and civilian detention staff on dangers associated with intoxication. This should include medical input.

6. 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 FMEs and custody sergeants.

Question 7: What specific considerations should be given to children and young people in custody to reduce risk of death/ serious harm?

Overview

Police custody is harmful to children (aged under 18), who are vulnerable due to their age. The custody environment can be an intensely frightening experience and many children in the criminal justice system are particularly vulnerable, having experienced physical, sexual and emotional abuse. A high proportion are in the care of a local authority. Detention of children presents a risk of self-harm and self-inflicted death following release. Children detained under section 136 Mental Health Act (s136) present an especially high risk given their additional mental health difficulties.

Overnight detention is particularly unacceptable. It is bound to cause significant distress and to prolong detention generally. Tens of thousands of children are subjected to overnight detention nationally.

Overnight detention often results from lack of alternative accommodation. There is a severe shortage of secure and non-secure local authority accommodation. Police officers frequently seek only secure accommodation without considering other options such as residential or foster care. These will be appropriate in many cases and secure accommodation should be reserved for exceptional cases. Police should also bail children to their own homes more frequently.

At its source the lack of local authority accommodation is a resourcing problem which has to be seen within the broader context of local authority spending and the impact of austerity.

Children who do not have family members to act as appropriate adults (AAs) are dependent upon AA schemes which are underfunded, with limited availability and variable quality.

Recommendations

1. Funding must be made available for **local authority accommodation** of children in police custody.

2. Local **joint working** is required between police forces and local authorities to identify the degree of unmet need.

3. The use of **police custody for children detained under s136 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.

4. Police **training and inspection** should focus on utilising non-secure accommodation for children other than in exceptional circumstances, with those circumstances clearly defined

5. Inspection of police custody should include the **length of detention** and the need to limit this to the shortest time possible, as well as overnight detention.

6. 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. Increased funding is required for **appropriate adult schemes** within a national framework for commissioning. This should include improved training and consistency of AA services.

Question 8: Are there any other issues that affect other vulnerable groups?

Overview

Those with learning difficulties often face particular challenges when they come into contact with the police. Sometimes the need for a different approach may not be immediately apparent and in other cases police officers lack understanding of how to respond. Situations can escalate into conflict and the dangerous use of force.

Vulnerable women face many of the same difficulties as vulnerable men, for example as a result of mental health difficulties. However they are likely to be impacted more severely for a number of reasons: They are more likely to be unfamiliar with police custody. They are likely to be primary carers of children and experience particular distress through separation, anxiety about childcare during their absence and fears about their children being taken into care as a result of a criminal conviction. They may also find the male custody environment more intimidating. Survivors of sexual and/or domestic abuse may find it more difficult to cope in custody. Strip searches are especially traumatic as is the (sometimes forced) removal of clothing on the basis of prevention of self-harm.

Recommendations

1. Police training on vulnerability should include understanding of and appropriate policing responses to those with **learning disabilities.**

2. The use of **support card schemes** should be developed by all forces and included in police training

3. Police training should address the **particular stressors that affect women detainees** (as set out below). In particular, officers should understand the additional impact of these stressors upon women with mental health difficulties and the importance of access to healthcare. Such training should take place in the context of training on gender awareness.

4. Custody procedures should be developed to **lessen the impact of separation of mothers from young children.** Research should be carried out nationally to explore this further. For example, telephone contact around childcare issues should be prioritised and visits with children and their carers facilitated for longer detentions. 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.

5. Vulnerable detainees should be **diverted from custody** at the earliest stage. Liaison and diversion schemes should extend to all vulnerable detainees.

Question 9: how can the police and other agencies improve the ways in which they work together?

Overview

Joint working with other agencies is at the heart of many of the problems identified within our replies to other consultation questions.

The main agencies with whom the police interact regularly in relation to vulnerable detainees are: Mental health services; ambulance service; accident and emergency departments; private companies providing custody and medical services in the police station; local authorities in relation to appropriate adults and local authority accommodation for children.

The extent to which such external services feature in the consultation and in inquest narratives and coroners reports demonstrates how many if not the majority of causes of deaths and serious incidents in police custody cannot be addressed by the police alone.

Inadequate medical care within the police station has been identified as a factor in many police custody deaths and the current arrangements for FME cover do not provide medical care of a consistent quality.

Recommendations

1. **FME and other medical services within police stations should be brought within NHS commissioning**, reversing the recent policy change in 2016. This is essential to introduce minimum standards of medical care in police custody.

2. **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.

3. A **national framework** should oversee the **consistency of services provided by private companies** operating in the detention environment to ensure consistent learning and implementation.

4. **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 behavior. A

national framework should oversee the existence of and consistency of such protocols.

5. All forces should work with local NHS commissioners and local authorities towards **eliminating the use of police cells for those detained under section 136 Mental Health Act and children.**

All forces should introduce **multi-agency training** on relevant issues, for example medical or child protection issues. A national framework should oversee and provide a consistency to such initiatives to avoid duplication and fragmentation.

Question 10b: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to police statements in the media

Overview

Misinformation and 'spin' has been a feature of many contentious deaths in custody where we have seen attempts by the authorities to tarnish the reputation of the deceased in order to deflect attention away from the act or omissions of police officers or public bodies. These attempts to demonise the person who has died and build up a negative reputation creates the idea of an 'undeserving' victim. Once this false narrative seeps into the public consciousness through the media it is difficult to challenge.

We have addressed this question within our response to Qu. 11 (family experience) at pages 3 to 4 and recommendations 2 to 4. We also make relevant recommendations within our response to Qu. 10c numbered 9 and 10.

INQUEST provided a detailed statement on this issue to the Leveson Inquiry which contained numerous case examples and this stands as part of our response to Qu. 10b and is attached at Appendix 5.

Question 10C: Conferring and separation of officers

Overview and Recommendations

A long-standing concern of bereaved families is conferring by officers in the immediate aftermath of a death, before and whilst they prepare their written accounts. Many deaths in custody occur either within the police station or where there are no independent witnesses. Often the medical evidence cannot establish the events preceding the death. Therefore very frequently the key evidence, sometimes the only evidence, on the central issues will be the accounts of the officers themselves. Furthermore, the opportunity to for police officers to confer occurs before the IPCC becomes involved and only the force to which the officers belong can enforce the immediate post-incident procedures.

Allegations of collusion undermine public confidence in circumstances where they can be difficult to prove or disprove. So long as officers remain together following a death many families will have suspicions which undermine their faith in the investigation. There have been many cases where the evidence has pointed strongly towards collusion having taken place. In other cases conferring can result in innocent contamination of accounts which is equally harmful for the integrity of evidence. Once officers have recorded their accounts they will become a central feature of the entire investigation and inquest process.

The current police guidance is that conferring on the reasons why force was used is prohibited, other than in limited circumstances. However in practice conferring can and does take place as officers spend many hours together in the aftermath of a death, both before and after the arrival of the IPCC, sometimes remaining together whilst they write their initial accounts before going off duty. A system that relies purely on trust cannot command public confidence and early separation of officers is the only way to ensure non-conferring in practice in a transparent manner. This is in both the interests of the police and the public as the current system undermines public confidence.

The IPCC has issued draft guidance on post-incident procedures which advocate separation (with certain caveats) which is currently awaiting approval by the Home Secretary (IPCC draft statutory guidance on achieving best evidence in death or serious injury matters 2014). INQUEST strongly supports the introduction of this guidance.

The College of Policing opposes separation of officers and has introduced a supervision requirement for firearms officers as a means of addressing concerns about conferring. INQUEST strongly opposes this arrangement as it involves supervision by senior officers from the same force which does not inject sufficient independence to meet family and public concerns. Furthermore, it is not clear whether the supervision requirements extend beyond shooting cases to other deaths in custody and following the use of force such as restraint deaths. Supervision applies only from arrival at the

police station, whereas officers frequently spend considerable time at the scene following a death and travel back to the station together. It also only applies to officers who have used force, not to officer witnesses.

Question 10c: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to IPCC investigations

Overview

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. However 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.

The overriding need identified by every family is to establish the truth about how their loved one died, to hold those responsible to account and to bring about changes to prevent further deaths occurring. The IPCC's processes and approach need urgent further development and reform to achieve what should be these common aims.

The IPCC has taken a more robust approach publicly on some issues, particularly around its proposed guidance on separation of officers to prevent conferring. This watchdog role should be exercised publicly more often to inspire public confidence in the independence of the organisation.

Recommendations

IPCC and Families

1. **Written information about sources of specialist support** including information about INQUEST, should be given to every family at first contact with an IPCC representative (see also our recommendations at Qu 11).

2. Families should be told from the start of their **right to independent specialist legal advice** and the **benefit of securing advice from the**

earliest possible stage. Irrespective of any questions of fault or liability, the complexity and pressures of the processes should justify this approach. A family may choose whether to take up this option. This information should be repeated during the progress of the investigation if the family have not sought advice at the earlier stage.

3. **Families should not be 'managed' but treated as an equal party in the process**, holding important views and insights and a detailed knowledge of the evidence.

4. **Families should be involved with staff training** including on the impact of a traumatic bereavement

5. IPCC staff should to be vigilant around **language and communication with families**. Families should be invited to express concerns about anything said by IPCC staff which may give rise to doubts around independence. This should form part of the IPCC's learning and development around engagement with families.

Early Stages

6. The IPCC should be resourced to provide a **24 hour national 'post incident' team** with sufficient national coverage to ensure attendance at a death in custody (DIC) scene within the shortest possible timeframe. Those attending should have clear working instructions detailing all steps necessary to protect a potential crime scene and secure and protect evidence.

7. **Police forces should be held to their responsibility for protecting DIC scenes and evidence** until arrival of the IPCC. Any failure to fulfill this role should be treated as a misconduct issue.

8. Officers in any way involved (directly or otherwise) in the circumstances leading to death should be **separated to prevent conferring**. This should be the responsibility of the Chief Constable (or appropriately named senior officer), supervised by the IPCC on arrival and failure should be tied to gross misconduct action. See our separate submission on conferring and separation.

9. Forces should be prohibited from issuing **press statements** following any death or in circumstances where a person is hospitalized in a serious condition and an independent IPCC investigation is likely.

10. Any attempt by police officers to **discredit the deceased or family members** should be a gross misconduct issue and should form part of the IPCC terms of reference.

11. Where a person has been **hospitalised in a serious condition and unlikely to survive an independent investigation** should be initiated by the IPCC promptly. This is necessary to prevent police forces seeking to secure evidence in the period before death (house searches,

speaking to witnesses, seeking hospital test results etc) which may undermine the independence of a later IPCC investigation and may be intended to discredit the deceased.

12. Strict limits should be in place concerning **evidence gathering by police officers** in a potential DIC case, where the person is hospitalized in a serious condition. This should be tied to misconduct action.

13. Independent investigations should be conducted into **near-deaths and other serious incidents in police custody**. Referral of such cases by police forces to the IPCC should be monitored.

14. 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. An investigator's 'ownership' of investigation findings has become confused and new written guidance needs to be issued.

15. **Terms of reference** should identify all key issues to be addressed. Terms should be amended to identify further emerging key issues. This is important to maintain an overview and for the Commissioner to ensure these have been properly addressed before signing off investigation reports.

16. The **CPS and/or HSE** should be informed of every new DIC case at the outset, for the earliest possible consideration of criminal conduct and for input/advice on evidence gathering and the conduct of interviews. The IPCC/CPS new working guidance and any similar HSE/IPCC protocol should be published and incorporated into IPCC practice across all regions and all investigations.

Investigation and reports

17. **Conduct investigations:** the low threshold for investigations to be conducted as a potential disciplinary or criminal investigation should be rigorously applied and monitored (see response to Qu. 10f).

18. **Police interviews** need to take place quickly regardless of whether a "DSI" or conduct investigation is taking place. Delays of months and longer are common, impacting on evidence gathering and adding to the overall delay. Timeframes should be introduced to ensure officers' accounts are obtained at interview as early as possible. Where it is considered necessary to put further evidence in interview, later additional interviews can be conducted. Pre-interview disclosure should be carefully limited.

19. **Disclosure**: Clearer guidance and monitoring are required of the withholding of evidence from families and the application of the 'harm test'. Fears of prejudicial impact if families receive access to documents are generating too much caution and inconsistency across cases.

20. Investigations should maintain a strong focus on obtaining **independent evidence**, including prioritising CCTV and independent witnesses during the 'Golden Hour' and appropriate instruction of experts.

21. The **quality and consistency of investigations** and report writing need to be improved with better **organisation-wide learning and development of specialist knowledge** shared across investigations.

22. Internal training and monitoring is required by the IPCC in relation to decisions applying the test for **whether there is a case to answer and on referral to the CPS, to ensure their consistent and proper application.** CPS Referrals should be made in advance of 6 months in cases where common assault charges are a possibility.

23. An **overiding 'duty of care' to ensure safety and welfare** should inform the review of all policing action. This should sit as the primary focus for all aspects of the IPCC investigations, particularly concerning findings and recommendations, countering the bitty and piecemeal treatment of issues with the resulting loss of overview.

24. **Better checks and management structures** should be in place at every stage to ensure investigations and final reports are meeting required levels of quality and competence. Reports should not be signed off by Commissioners unless they properly identify, systematically address and reach findings on all key contentious facts and issues surrounding a death.

25. **Internal development is** needed across key areas and common emerging themes (eg mental health, intoxication, restraint etc) to develop more specialist understanding of issues. There should be dynamic working documents capable of regular review and updating to reflect investigation experience and developing expertise.

26. **Better internal structures and training** are needed to share knowledge, expertise, understanding and confidence across staff. Too often key issues are missed or not adequately addressed with the impression that investigators start from a blank sheet despite other investigations raising common issues and concerns.

27. The use of **former police** officers needs to be brought to an end. Ex – police officers should not work as investigators. To the extent that the IPCC still consider this expertise is required, ex-police staff should act as an internal (or external) consultancy source within the organisation.

28. **Regional consistency**: Best practice changes need to be implemented across all the regions.

29. Internal training and written guidance needs to be established to tackle **poor and inconsistent misconduct decision making** (see response to Qu. 10f).

30. **Post -inquest investigation reviews**: written guidance should be published setting out how/when the IPCC reviews investigations post–inquest/ post-trial, to take account of fresh evidence, including re-visiting misconduct and criminal issues.

31. **Case end reviews** should be conducted for internal learning and development.

    Improving policing practice and 'watchdog' responsibilities

32. The IPCC should do more to **publicise key decisions** during the investigation process to aid transparency and provide a source of external pressure and learning. This is happening recently but not consistently. This should include examples of poor (or good) force conduct and responses, for example around suspension, retirement and misconduct issues.

33. More is needed around **recommendations designed to highlight poor or dangerous practice or learning from good practice.** There is a need for clarification and development of how the IPCC can better feed into **wider systems of oversight and learning** (locally and nationally) to maximise positive change (see response to Qu. 14 and 15).

Question 10d: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to the role of the Crown Prosecution Service and the criminal justice process

Overview

Many families have voiced their frustrations that the criminal justice system has failed to deliver accountability, particularly following deaths involving police use of force. INQUEST has long argued that families are not treated as 'victims' within the criminal justice system and that deaths are not treated as potential crimes from the very outset. Police conduct which is potentially criminal is not subjected to the same investigative steps as criminal offences committed by civilians. This leads to the long-standing perception that police officers are 'above the law' and protected by the system.

Recommendations:

1. The **Memorandum of Understanding between the IPCC and CPS** should be published and applied consistently.

2. The IPCC should maintain close monitoring of **decisions on referral to the CPS** to ensure they are made consistently and to the required standard.

3. The CPS should adopt a strategy that places at its heart an understanding of the **vital public interest in establishing parity between police officer and civilian prosecution processes.** Such a strategy will underpin the recommendations below.

4. The **CPS specialist unit** dealing with prosecution decisions about police officers must be better resourced to avoid **extreme delays**. This is particularly timely given the current expansion of the number of independent investigations being conducted by the IPCC alongside the increase in CPS referrals.

5. CPS caseworkers should be trained to fully appreciate the need for the **CPS to demonstrate that the criminal justice system does not favour police officers** in its prosecution decisions and the corresponding need to adopt a rigorous merits-based approach to decision making.

6. The CPS must demonstrate that in its **choice of counsel** to advise on prosecution decisions and to prosecute on behalf of the Crown consideration has been given to the critical need for impartiality and robustness in this sensitive role. Consideration should be given to a specialist panel for prosecutions of police officers.

7. The IPCC and CPS should focus on the use of **medical and forensic expert evidence** to build a prosecution case. However the use of so-called restraint experts should be clearly defined and limited to factual evidence on force guidelines and training and not opinion evidence on the use of force in the particular circumstances of the case.

8. Clear **protocols should be adopted between the IPCC, HSE and CPS** in respect of prosecution decisions around management failings to ensure a streamlined process. A Memorandum of Understanding encompassing both health and safety and corporate manslaughter offences should be published.

Question 10e: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to coroners' inquests

Overview

INQUEST has played a key role in reform of the coronial system. The Coroners and Justice Act has brought about important changes including with the appointment of the Chief Coroner, with increased focus on coroner training and 'guidance notes' to aid national consistency. However, key problems continue and for many families, the experience of police inquests continues to be a painful, stressful and deeply frustrating experience. Families commonly refer to the re-traumatising impact of the inquest hearing.

Fundamental to any coronial change must be the recognition that police related inquests are, with few exceptions, specialised and contentious cases, highly adversarial in nature, often with state bodies pursuing the primary objective of damage limitation.

Recommendations

1. **Written information about sources of specialist support and advice** including information about INQUEST and the right to legal advice and representation should be passed to every family by the Coroner's Officer at the first contact (see response to Qu. 11).

2. **Family room**: all families should be provided with an appropriate and exclusive space.

3. **Family designated court space**: families should be given designated court space according to their needs, to prevent battles for seats and family members being surrounding by officers.

4. **Photo and 'pen portraits'**: all coroners should be instructed to follow the best practise followed at Hillsborough, permitting a family to produce a photo of the deceased (to be shared with the jury) and allowing a family member to give a full and personal 'pen portrait' of their loved one.

5. **National Coroner Service**: a nationally funded service is required to prevent the current and inconsistent patchwork of local authority funding arrangements.

6. **Specialist Article 2 coroners**: a team of specialist coroners is needed to ensure better consistency and to address many of the

concerns and issues raised above: to ensure experience and appropriate training in how to manage and effectively deal with these contentious, political and highly complex cases, protecting against bias and allowing development of a specialist overview around significant and contentious issues such as restraint, 'excited delirium', mental health, intoxication.

7. **High Court judges:** consideration should be given to a greater use of judges in complex cases along with counsel and solicitor to the coroner.

8. **Guidance on Article 2 inquests:** clear instructions and guidance are needed for coroners across all key aspects relevant to an Article 2 inquest. These should be dynamic/working documents subject to continual review and amendment to incorporate best practise. Key areas should include: conflict questions to the jury, a coroner's opening to the jury (including background facts setting the scene, directions to jury on their right to ask questions, key issues/concerns to be addressed in an Article 2 inquest) summing up and jury directions, neglect, unlawful killing.

9. **Disclosure:** clearer coroner rules are needed with the development of inter-agency guidance/working instructions (Coroners Court, CPS, IPCC, HSE) to provide clarity for the responsibility and management of disclosure and to facilitate full and earliest possible disclosure to families and their representatives. This is particularly important were confusion arises during parallel criminal and/or misconduct investigations and where family members are witness to events. Guidance/working instructions should identify clear lines of responsibility in terms of 'ownership' of documents and decision making about the release of documents. Guidance should include duties on state bodies to provide disclosure to the coroner and disclosure to families of documents considered to be potentially relevant.

10. **Document management**: guidance is needed from the Chief Coroner on document management and the preparation of bundles.

11. **Experts**: there is a need for Chief Coroner guidance on the use, selection and instruction of experts.

12. **Delay**: given the delays in IPCC investigations and related HSE/CPS proceedings, coroners should have greater powers for case management to ensure better co-ordination of the various bodies and speedier progress in the processes underway. Statutory agencies could be required to report to the coroner, to ensure more rigorous and effective time management of the related

processes, requiring relevant bodies to account for delays. Increased guidance and powers would help extend active case management across all coroners' courts.

13. **Family representation**: families must be given non-means tested publicly funded specialist legal representation immediately following death. Funding for a QC and junior should be available in contentious cases involving multiple interested parties. Anything less represents a fundamental inequality of arms.

14. **Police witnesses**: police witnesses should not be permitted to sit and hear evidence ahead of giving evidence. Without exception, families raise this as a matter of concern during hearings.

15. **Treatment of family witnesses**: clear and strict guidance should be in place for the protection of family witnesses to prevent aggressive and inappropriate lines of questioning and recognising the painful and often traumatic experience of giving evidence as a bereaved relative. Any tactics designed to smear or discredit should be halted immediately and raised by the coroner and/or IPCC with the Chief Constable.

16. **Conduct of barristers acting for police forces:** Chief Constables should hold the line of responsibility for the conduct of their legal counsel at inquest hearings and inappropriate strategies should be brought to the attention of the Police and Crime Commissioner.

17. **Separate/multiple legal representation**: Coroners should keep live the question of whether conflicts exist sufficient to justify the appointment of separate counsel for individual officers. Coroner guidance is needed on when separate representation should be permitted.

18. **Complaints**: the Chief Coroners office should become responsible for complaints concerning coroners. This would ensure greater visibility across the system, helping to direct training needs and development.

19. **Consultative/Advisory Group**: should be established by the Chief Coroner's office to enable transparency and more effective input around the development of written guidance to coroners. There should also be an advisory group/forum for bereaved people and those that advise them to feed back on the coronial system.

Question 10f: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to the police misconduct and disciplinary process

Overview

The historic and on-going failure of either the IPCC or the police to adequately act on misconduct issues arising in police related deaths has been a cause of longstanding anger and incomprehension for families. For many it represents yet another fundamental failure by the system to ensure justice or accountability. Families describe officers sitting above the law and a different set of rules applying when those involved in the most contentious deaths are neither punished nor hindered in continuing their policing roles and careers.

The lack of appropriate disciplinary action undermines public confidence and acts as a barrier to institutional change.

IPCC misconduct decisions are not sufficiently rigorous or consistent, often focusing on more junior members of staff, with the actions of more senior staff and management remaining outside the misconduct framework. The IPCC approach to individual officer actions fails to address management level misconduct issues surrounding widescale failures around systems, training and the breakdown of basic policing functions and duties common in many police custody deaths.

Forces are failing to take appropriate steps: refusing to suspend officers subject to serious criminal and misconduct investigations, to follow IPCC recommendations and, most concerning of all, refusing to dismiss officers found guilty of gross misconduct.

Recommendations

1. **Conducting the IPCC investigation as a potential disciplinary or criminal matter**: the threshold for conducting investigations on this basis is low. Although there have been improvements, with the IPCC serving misconduct notices early on in some investigations, a more rigorous and consistent approach is needed,. This includes both very early decisions following a death and review throughout the life of an investigation. There should be improved internal IPCC guidance and training.

2. **Prompt interviews:** the IPCC are consistently failing to carry out prompt misconduct and/or criminal interviews, causing delay, potentially weakening evidence and undermining family confidence in the process. Equivalent delays do not exist in the context of

other types of misconduct and criminal investigations. Timeframes should be introduced to ensure officers' accounts are obtained at interview as early as possible. Where it is considered necessary to put further evidence in interview, later additional interviews can be conducted.

3. **Management failings:** Consideration should be given to disciplinary issues at management level, in addition to misconduct by officers directly involved in the death.

4. **Suspension**: the IPCC should always 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 investigation. The need to request a suspension should be treated by the IPCC as a live and ongoing issue to be considered and re-visited at every appropriate stage in the investigation. Internal working documents are needed to ensure this is not forgotten or missed.

5. **Force refusal to suspend:** a decision to refuse an IPCC request to restrict the duties of or suspend an officer should be a matter for the Chief Constable. Given the wider serious public and community implications of a force's refusal to suspend an officer, any such refusal should be notified to the Police and Crime Commissioner and to the Home Office to ensure transparency and oversight of this critically important aspect of accountability. The IPCC should make public any such refusal.

6. **Resignation/retirement:** it should be mandatory for a Chief Constable to immediately inform the IPCC and the family/family's legal representative of any intention by an officer subject to a conduct investigation to resign or retire. In such circumstances, the IPCC should be required to invite the views of the family and consider making representations to prevent that officer's departure**.**

7. **Inadequate decisions on disciplinary action by the IPCC:** recommendations for disciplinary action continue to be weak and inconsistent. High profile cases can generate comprehensive gross misconduct recommendations whereas other cases raising similar failures and concerns often result in little more than management advice or training. Clear internal training and monitoring is required by the IPCC in relation to its decisions when applying the test for whether there is a case to answer, to ensure its consistent and proper application.

8. **Distinguishing simple misconduct from gross misconduct:** the IPCC should include the criteria it adopts in its statutory guidance.

9. **Forces refusing to follow IPCC recommendations**: it is common for IPCC recommendations to be rejected or watered down. Any such refusal should be notified to the Police and Crime Commissioner and to the Home Office to ensure transparency and oversight. The IPCC should make public any such refusal.

10. **Families' engagement with misconduct hearings:** a Chief Constable should hold responsibility for informing the IPCC and the family/the family's legal representative as soon as a disciplinary hearing is arranged. Adequate notice must be given to enable a family to exercise their right to be present and to participate in the process. The family's right to be accompanied by a legal representative and to be assisted by him/her to formulate questions to witnesses should be made explicit.

11. **Sanctions for gross misconduct:** dismissal should result following the overwhelming majority of gross misconduct findings.

12. **Promotion:** officers should not be promoted prior to the conclusion of any disciplinary process.

13. **Pension deductions:** where officers are found guilty of misconduct this should be reflected in deductions from pensions, whether following dismissal or not.

14. **National Leadership:** given the highly contentious and historically poor outcomes in this area, there is an urgent need for leadership by national policing bodies on this issue, to introduce culture change, transparency and a level of central oversight.

Question 10g: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to investigations by NHS Trusts or other medical healthcare providers

Overview

The issue of NHS investigations arises where either someone has died in an NHS setting, with the police present and involved, or where failures by mental health services have led to a person in crisis coming into contact with the police.

In conducting the IPCC investigation, issues around the interface between

police and NHS should be properly addressed. Too often we see lines drawn between 'police' and 'health' matters without sufficient consideration of relevant overlaps, including cross-agency policies and practices.

Co-ordination between the investigations by and into NHS Trusts and other medical bodies with the IPCC investigation and any HSE or CPS involvement is important, also to avoid unnecessary delay, confusion and inconsistency. See for example the plethora of investigations following the death of Olaseni Lewis at Qu. 10h page 3.

INQUEST has campaigned extensively around the lack of an independent investigation mechanism for deaths in mental health detention (as there is for deaths in police and prison custody). We remain extremely concerned about the quality of internal NHS investigations in a wide range of deaths of psychiatric patients. The same concerns apply to the deaths of patients within psychiatric hospitals who die following police involvement including restraint (see our response to Qu. 4 pages 22-24). See INQUEST's report 'Deaths in Mental Health Detention: an investigation framework fit for purpose?' which is attached as Appendix 6.

It is essential that whoever is conduction the investigation ensures that the family are able to play an effective and meaningful role and are kept informed of progress. Many families have played an important role in their relatives care and have vital insight and experience that can help inform the investigation and its findings.

Question 10h: Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to the role of the Health and Safety Executive

Overview

INQUEST welcomes increased HSE involvement and the greater consideration of health and safety (H&S) offences in police custody deaths, including those involving the use of force. H&S offences are an important but underused tool of accountability, particularly for addressing systemic failures and corporate level responsibility surrounding a death. We would welcome a greater and more consistent consideration of H&S issues across police deaths, including increased focus on management of custody procedures.

Recommendations

1. There should be greater consideration and **utilisation of H&S offences** across all police related deaths. This should include **systemic failures in monitoring, implementation and training** on procedures intended to protect life, including custody safety and use of force.

2. **Consideration by the IPCC of H&S offences**, and where appropriate the engagement of the HSE, should **start from the outset of every case**, ensuring that all processes (HSE, CPS and inquest) run in parallel to prevent delay.

3. The IPCC should put in place **guidance and training for investigators** on evidence gathering and decision making in relation to management level failings.

4. Current working **protocols between the HSE and IPCC** should be published and reviewed.

5. Guidance should be developed between the CPS and HSE identifying those **aspects of police custody cases that the HSE remain best placed** to address.

6. The **CPS should deal with all other H&S offences** as part of the full picture of criminal conduct across a case.

7. Clear working guidance should be developed on the timescales and approach to be adopted by the HSE, including in their **engagement with families and other bodies (IPCC, CPS, coroners)**

8. Protocols should be developed to identify and promote **more effective and clearer joint** working on cases where the IPCC, HSE and CPS all have involvement.

Question 11: In what ways could family experience, involvement and support be improved at all stages after a death has occurred?

Overview

Bereaved families have to cope with a traumatic loss at the same time as navigating a complex set of legal processes. They are not recognized as 'victims' within the various systems and do not benefit from any automatic support such as that provided by the police and Victim Support to those treated as victims of crime.

Families' experiences vary a great deal, often depending on whether and at what stage they access specialist advice and support. Whether they do so and when is frequently a matter of chance.

Many families suffer from a lack of information in the early period immediately following a death. This includes delays in being informed of the death, lack of information about the post mortem examination and their right to a second post mortem.

Some families have been caused extreme distress in the early days following a death due to police and the IPCC releasing information to the public which seeks to defend the police position and tarnishes the reputation of the deceased.

Some families find that their contacts within the police and IPCC, whether through family liaison officer or investigators, are uninformative and insensitive, displaying a lack of humanity and empathy to them as bereaved people.

Most families are not informed of their right to legal advice and representation for the inquest. Many are not aware of INQUEST and do not access any specialist advice for some time.

Many families feel that they should receive non means tested legal aid as of right given that their relative has died under the control of the state and the state bodies are always legally represented. A great many find the legal aid means assessment process intrusive and prolonged. Others face a battle to persuade the Legal Aid Agency that they come within the guidelines for exceptional funding for inquests.

Family members' access to counselling and other support, particularly for bereaved children, is patchy or sometimes lacking. The need for such services may arise soon after the death or not until some time later, for example after the inquest is over.

Families expect to have involvement in the IPCC investigation and to see a prompt and robust investigation which uncovers the truth. They are frequently increasingly disappointed as the investigation progresses and frustrated by inadequacies in the process and outcome. The reasons are elaborated in our reply to this question and to question 10c.

Recommendations

1. All forces and the IPCC should agree protocols to **prioritise notifying the family as soon as possible after a death**. Where possible this should be done face to face unless this will create unacceptable delay.

2. **No information should be released to the media** until after the family has been informed of the death.

3. Where the IPCC is conducting an independent investigation a **police force should not release information to the press or contact the family.**

4. Any information released by the IPCC should be limited to **outline facts and be agreed with the family.**

5. Coroners' courts should provide **information to families about the post mortem** examination before it takes place. This should include the time and location of the examination, their right to have a representative present, their right to arrange a non-invasive post mortem, their right to obtain a second post mortem and their options regarding retained tissues.

6. Families should be informed of their **right to have the draft post mortem and the final post mortem** released to them.

7. All families should be able to **view the body** as soon as they wish and before the post mortem examination.

8. All families should be provided with **written information about support services and their rights in outline**. This could be in the form of a fact sheet including contact details for INQUEST (with a link to the INQUEST handbook) and other support services.

9. All families should be informed of their **right to legal advice and representation for the inquest** and that it is desirable for them to participate in the inquest process.

10. Information about support services and the right to legal advice should be provided to families **at first contact** by:

    a. Coroners' Officers
    b. IPCC representatives
    c. Local police force representatives (where police investigate the death)

11. **Non-means tested legal aid funding** for inquests should be provided as of right in all police-related deaths.

12. There should be **funded access to a national network of appropriate bereavement services**. Families should be provided with information about referral to specialist counseling and other support services.

Question 13: What could be done to improve accountability on the part of the police in relation to deaths and serious incident in police custody?

Overview

We refer to our replies to Question 10 on the coroners inquest, police disciplinary system, and roles of CPS and HSE as our reply to Question 13.

INQUEST's experience is that families feel frustrated with many of the legal processes that they come into contact with. The fundamental reason for this is that none of the four legal systems that exist in the UK which potentially apply to deaths in custody are structured to provide such accountability (in the majority of cases). Therefore families and their legal representatives have to struggle to extract accountability within each of these legal frameworks.

1. **Coroner's inquest**
   At the heart of the inquest system is a no blame principle and the rules prohibit findings that determine civil liability or criminal liability by a named person. State bodies use this to attempt to limit critical findings.

2. **Police disciplinary system**
   This is primarily an employment law mechanism which determines the relationship between the force and its officers. It is not geared towards providing outcomes for families.

3. **Criminal law system**
   This could provide accountability in some cases if the processes operated properly. However, the threshold for establishing a crime is high. Many failings around deaths in custody are not criminal.

4. **Civil law system**
   The area of law most suited to securing accountability is civil law, which is directed towards making findings on who is responsible for a death. Most of the failings in deaths in custody fall easily within civil concepts such as breach of duty of care, failure to apply policies and failure to take reasonable steps to protect life. However, the civil law system is structured towards pushing parties into out of court settlement. The vast majority of cases end this way, usually without an admission of liability or apology. Although families receive compensation there are no findings by a court to establish accountability. Many cases settle without even an application to the court, so the issues are never aired.

Given the gap that exists within our legal systems, if families are to achieve accountability, each of the legal processes has to be actively adjusted towards this and an overall framework is required for national learning and implementation of the lessons arising from deaths.

Question 14 & 15: What could be done to improve sustained learning from deaths and serious incident in police custody? How can there be more effective implementation of learning and recommendations arising from investigations and inquests into deaths?

Overview

- The current system lacks national oversight to ensure visibility, implementation and sustained change in response to the issues and failures identified through the investigation and inquest process of police related deaths.

- Investigations, inquests, inquiry reports, Inspectorate and monitoring board reports, jury findings and coroners' recommendations are critically important sources of evidence concerning risks to the health and safety of people in custody. However, the State has so far failed to implement a framework that produces tangible meaningful actions for the prevention of future deaths or for establishing structures of democratic accountability.

- INQUEST's analysis of jury findings and coroners' reports within the dossier prepared for the Independent Review demonstrates the rich potential of a systematic approach to extracting the learning from inquest outcomes.

- A key obstacle to reform and sustained change is the lack of rigour, transparency and accountability of state institutions, as well as the relevant Government ministers, to take action to rectify identified and dangerous systemic problems and the need for a more co-ordinated response by the regulatory, investigation and inspection bodies.

- At present all we have are fragmented, ad hoc initiatives lacking in continuity. Recommendations are not monitored or followed up in any systematic way. To the extent that change is achieved, it is often not sustained. Actions peter out only to be raised again

several years later by different bodies. In the meantime deaths continue to occur in circumstances involving the same issues and failures.

- There is currently no established framework between the national oversight bodies Independent Police Complaints Commission (IPCC), HM Inspectorate of Constabulary (HMIC), Independent Custody Visitors Association (ICVA), Police and Crime Commissioners (PCCs), National Police Chief's Council (NPCC) and National College of Policing (NCP) concerning inquest outcomes and the implementation of necessary learning.

- No administrative framework has yet been developed to maximise the preventative role of the coronial system. Jury findings are not collated or published and whilst Coroners' reports are now published on the judiciary website there is no audit of progress or follow up to ascertain the impact of these reports at a national or local level and there is no power to compel action to be taken.

Recommendations

1. 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.

2. As well as ensuring vital learning, this would also assist the national oversight bodies to fulfil their vital function and help play a strategic role in the protection of people in custody. Providing a knowledge and evidence base would help shape and inform their work, ensuring the sharing and dissemination of information, guidance and recommendations.

3. Effective structures of accountability sit at the heart of the cultural reforms needed to truly implement changed thinking and approaches. Misconduct and disciplinary action, employment consequences and successful prosecutions play a central and critically important role to that change. We refer to our comments under those separate sections.

4. A mapping exercise is needed of the post death structures and processes for the dissemination of information and learning arising out of investigations and inquests into police related deaths. This

should identify all relevant bodies with an involvement in that process (investigation, inspection, oversight, regulation, training bodies) with details of any interlinking arrangements and working protocols. The oversight bodies should be automatically copied into all IPCC investigation recommendations and all inquest conclusions and Prevention of Further Death reports, and have a duty to make public the action taken in response.

5. As well as helping clarify where responsibility for learning and change is currently sitting within the system, this should also help direct Coroners, the IPCC etc. on where to address recommendations and how most effectively to direct their learning responsibilities.

6. The same exercise should be conducted for police forces, showing where/who/how responsibility sits internally for force knowledge, learning, implementation that flows from police death cases. Again, this would be helpful for increased visibility, and also for ensuring better monitoring and accountability.

7. Parliamentary oversight (possibly by a Parliamentary Select Committee) should annually review and monitor inquest conclusions and Prevention of Further Death reports arising out of police cases, to track and highlight issues and trends (in reality this would be a relatively small number of cases). The IPCC, HMIC, NCP should all be required to feed into this review process.

8. The Home Office should provide a response to the annual review, to ensure high level political focus and scrutiny and to help provide a further national focus for sustained learning.

9. National uniform systems and practices across police forces would enable greater clarity and consistency. At the moment every police force operates individual policies and operational practice. Learning should be centralized and rolled out nationally rather than locally or regionally.

Conclusions

Our analysis of jury findings and Coroners' reports within the dossier prepared for the Independent Review demonstrates the rich potential of a systematic approach to extracting learning outcomes from the combined findings of an inquest. However, what this analysis highlights is the failure of existing modes of accountability and learning.

INQUEST has long argued that proper creation, publication, dissemination and analysis of recommendations, and their implementation, could benefit a wide range of institutions and people. This feature of our work has contributed to the development of our critical analysis of the investigation of deaths in custody and also to our work to improve the current system. This has formed the basis for our analysis in successive reports, in particular *Unlocking the Truth* (2007) and *Learning from Death in Custody Inquests: A New Framework for Action and Accountability* (2012). Our engagement with the Independent Review aims to be part of that continuing process.

INQUEST has previously recommended that a Standing Commission on Custodial Deaths be set up[8] . It would consolidate the experiences of the separate investigative bodies, monitor the outcomes and progress of inquest findings and recommendations, develop policy and research and promote and disseminate good practice. The Standing Commission would have an independent Secretariat which would include representatives from community, family and other interested groups.

No administrative framework has yet been developed to maximise the preventative role of the coronial system. Jury findings are not collated or published and whilst Coroners' reports are now published on the judiciary website there is no audit of progress or follow up to ascertain the impact of these reports at a national or local level and there is no power to compel action to be taken. We have noted above how an embryonic attempt at such a systemic analysis by the Ministry of Justice between 2008 and 2013 did not provide meaningful data and has not been replicated since the establishment of the role of Chief Coroner.

In responding to the Harris Review of deaths of young adults in prison all the recommendations concerning learning and accountability were rejected by the Government. Instead they relied on the existing status quo and the *'considerable information available following a death in custody.'* and saw no need for centrally collating inquest findings and making them available for public search. They confirmed that "*there were no plans to centralise the function* and …*no current plans to enable further work on the themes of PFD reports"*[9]. The Government's complacent response to the Harris Review fails to grapple with the fact that the existing systems do not adequately address the problem of custody deaths, hence we continue to see similar deaths year after year.

There is an urgent need for a stronger focus on implementation of recommendations and coroners' reports. Other jurisdictions provide useful

[8] House of Lords and House of Commons Joint Committee on Human Rights 2004; Goldson and Coles, 2005, Shaw and Coles 2007 (Unlocking the Truth); INQUEST Learning from Deaths in Custody Inquests: A New Framework for Action and Accountability 2012

[9] Government response to Harris review Dec 2015

blueprints when considering pathways to reform. Mechanisms for reporting and ensuring accountable learning are far more developed in New South Wales, Australia and in Ontario, Canada and are an integral part of the coroner's system and strictly monitored. In Australia, findings are tabled in parliament and are therefore on the political agenda and potentially a vehicle for change. Australia has a National Coroners' Information System which is an on-line publicly accessible database containing all information arising out of inquests.

Fundamentally, a more robust and effective framework following custodial deaths requires resourcing and political will on the part of national Government. Any new framework should also be accountable to Parliament to enable the advantage of parliamentary oversight and debate. Consideration could be given to its reporting annually to Parliamentary Select Committees.

A proper framework for responding to the findings of investigations into custodial deaths could provide a new avenue to address some of the fundamental problems highlighted in our response to the Review. It could have a deterrent effect, create systems for the prevention of future deaths and near deaths and help to re-establish confidence in public bodies by addressing the accountability gap that currently exists. Whatever mechanism is put in place must directly link to Government policy making. The findings of post-death investigations inquest juries and Coroner's reports should be available to all engaged in thinking about, and legislating for social and criminal justice policy.