Home Office

Deaths in police custody: Government Update – 2021

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1. Introduction

1.1. The UK Government is committed to delivering meaningful and lasting change to prevent deaths in custody and support families. That is why on 23 July 2015, then Home Secretary Rt Hon Theresa May MP announced a major review of deaths and serious incidents in police custody, focusing on the experience of bereaved families. This followed the former Home Secretary's meetings with bereaved families who made clear that the system was not fit for purpose; not only in preventing deaths in police custody, but also ensuring that families are supported throughout the process and that lessons are learned and implemented quickly.

1.2. The Rt Hon Dame Elish Angiolini DBE QC's Independent Review of Deaths and Serious Incidents in Police Custody was published on 30 October 2017 (' the Review'). The Government's substantive response was published on the same date.

1.3. The Review made 110 recommendations to Government departments, police forces in England and Wales and public sector organisations. Many of them are cross-cutting and multi-disciplinary in nature. The review looked at the events leading up to such incidents, as well as existing protocols and procedures designed to minimise the risks. It covered the immediate aftermath of a death or serious incident and the various investigations that ensue. Crucially, it also focused on how families of the deceased are treated at every stage of the process.

1.4. On 12 December 2018, the Government published a progress update on the implementation of its response. The 2018 progress update focused on three main themes: supporting families, strengthening accountability and preventing deaths.

1.5. Since the publication of the 2018 update, significant progress has been made in further addressing the Review's recommendations with departments and agencies driving a work programme to ensure that future deaths are prevented, and families are fully supported when these rare, but tragic events do occur.

Context

1.6. Deaths in, or following, police custody are defined as those deaths that happen whilst a person is under arrest, or detained under the Mental Health Act 1983, or where a person is no longer detained but their death arises from injuries or medical problems that developed or were identified during their detention. This includes deaths that occur within a police custody suite, but also on private or medical premises, or in transport to or from these premises, or in any other public place.

1.7. Since the late 1990s, there have been large reductions in the number of deaths in or following police custody[1], but it is essential that deaths in police custody continue to reduce as far as possible. The reduction reflects measures such as removing ligature points in custody suites, more regular cell checks, logging of checks on custody records,

[1] Figure 1, Page 15. Home Office (2017), Deaths in police custody: A review of the international evidence

observations levels for the particularly vulnerable, and better risk assessments of people entering custody.

1.8. The demographics of those who die in police custody in England and Wales are typically male, aged between 31 and 50, and from a white ethnic background. Natural causes are the most common known cause of deaths in police custody in England and Wales between 2004/05 and 2014/15, accounting for 51% of deaths in this period. Drugs and/or alcohol also featured as causes in around half of deaths (49%).

1.9. In 2019/20, there were 18 deaths in or following police custody, an increase of one from 2018/19. This is in line with the average figure for over the last decade. 14 of the deceased were white and three were black; one person's ethnicity was unrecorded[2]. The majority of individuals who died in or following police custody in the most recent year had links to drugs and/or alcohol. These figures are not unusual when looking at long-term trends. Eight of the 18 people who died in 2019/20 had some force used against them either by officers or members of the public before their deaths. However, the use of restraint, or other types of force, did not necessarily contribute to the deaths.

Governance

1.10. As part of its response to the Review, the Government commissioned the Ministerial Board on Deaths in Custody (MBDC), which brings together Ministers, senior officials, experts and the Independent Advisory Panel on Deaths in Custody (IAPDC), to play a leading role in considering the most complex of the Review's recommendations. The purpose of the Ministerial Board is to prevent and reduce the number and rate of deaths in all forms of state custody - including prison, approved premises, in or following police custody, immigration removal and those detained in hospital under the Mental Health Act - in England and Wales.

1.11. Many of the issues raised by the Review cover both health and policing. Health is devolved to Wales where policing is not. We have indicated in the text where health-related updates refer to England, Wales or both.

1.12. 65 of the 110 recommendations made by the Review have been delivered and a further 20 recommendations delivered in part. 12 recommendations were rejected completely with several more recommendations rejected in part.

1.13. The MBDC co-chairs, police forces, health partners and government departments remain focused on and committed to preventing deaths in custody, and in the tragic situations that they do occur, on holding organisations to account and supporting bereaved families, and tackling emerging themes, such as disparities.

[2] It should be noted that ethnicity data is only broken down into five broad categories (white, black, Asian, mixed and other) so it is not possible to draw conclusions at a more granular level than this.

Race and Ethnicity

1.14. The Government is determined to listen and act on issues of diversity, racism and discrimination. This update will consider where there may be a disproportionate impact on ethnic minority groups and where ethnicity is relevant within the overarching themes of the original Review. Race and ethnicity were not drivers of the 2017 Review and did not form one of its twelve primary themes although it did consider the extent to which ethnicity was a factor in incidents. This Government update therefore references recommendations specific to ethnicity within the Review, and further details are given in the Government's response to the Joint Committee on Human Right's (JCHR) 2020 report into 'Black people, racism and human rights'.

1.15. The Review made nine recommendations related to ethnicity: seven of these have been completed, one has been delivered in part and one is in progress (Recommendation 107: The IOPC should monitor ethnicity and deaths in custody against ethnicity and arrests by reference to all arrests, including non-notifiable offences).

1.16. Since the Review was published, there has been increased attention and scrutiny of disparities in policing in the UK. Dame Elish states in her report that: '*deaths of people from BAME communities, in particular young Black men, resonate with the Black community's experience of systemic racism, and reflect wider concerns about discriminatory over-policing, stop and search, and criminalisation'.*

1.17. Policing in the UK is based on the consent of the public with community accountability. The majority of officers in the United Kingdom are not routinely armed and the use of firearms by the police is always a last resort only used where there is a serious risk to public or police safety. Deadly force is used very rarely and this is a testament to the training, skill and judgment of firearms officers and commanders. There is also oversight by an independent inspectorate to ensure police conduct meets the highest possible standards.

1.18. We recognise that the police's ability to fulfil their duties is dependent on securing and maintaining public confidence and support for their actions, as part of the model of policing by consent. That is why we are working closely with the IOPC to examine how we can improve the accessibility, transparency and scrutiny of information regarding the relationship between ethnicity and restraint related deaths.

1.19. We acknowledge that there are racial disparities across the criminal justice system, reflecting wider social disparities. For example, we know that black people, in particular young black men, are over-represented throughout the criminal justice system. However, analysis of the ethnicity of those arrested or detained in police custody when compared with the ethnicity of those who have died during or following police custody during the last ten years is broadly in line and does not suggest that ethnicity impacts the likelihood of dying during or following police custody.

1.20. Data also does not suggest that black men are more likely to die in custody in cases where use of force or restraint is present. With such small numbers, no firm conclusion can easily be made as to whether there is a correlation between ethnicity and deaths caused by restraint. This evidence is outlined in the Government response to the Joint Committee on

Human Right's (JCHR) 2020 report into '*Black people, racism and human rights'*[3] and in the recently published 'Commission on Race and Ethnic Disparities: The Report'. Further work is underway to improve the presentation and accessibility of information regarding the relationship between ethnicity and restraint related deaths.

1.21. The causes of racial disparities in the criminal justice system are complex and reflect broader social inequalities which the UK Government is committed to tackling, including via the Inter-Ministerial Group on the Commission on Race and Ethnic Disparities, chaired by the Chancellor of the Duchy of Lancaster. The Government welcomes the recommendations from the Commission on Race and Ethnic Disparities to bridge divides between the police and communities and stress the importance of efficient, consistent de-escalation training and of both internal and external scrutiny of police use of powers. The Home Secretary has already committed to looking carefully at the role of local community scrutiny and body-worn video to achieve this[4].

2. Thematic Updates

Restraint

2.1. Police leadership have taken a number of steps to improve the training officers receive when using restraint and ensuring the health of detainees is monitored throughout the process.

2.2. The extent to which restraint techniques contribute to deaths in custody and whether current training is fit for purpose is a crucial aspect of the Review. Police use of restraint against detainees was identified as a cause of death in post-mortem reports in 10% of deaths in police custody between 2004/05 and 2014/15[5].

2.3. In September 2020, the CoP published national evidence-based guidelines for policing on conflict management, including de-escalation and negotiations skills. These are aimed at resolving conflict in everyday police-citizen encounters without using force by encouraging safer resolutions and therefore reducing the risks of assaults to the public and officers.

2.4. The recent National Police Chiefs' Council (NPCC) and CoP Officer and Staff Safety Review (OSSR) also encouraged Chief Constables to implement these guidelines. De-escalation and conflict management are key tenets of the Personal Safety Training national curriculum with an expectation that police forces will use this curriculum from April 2022. The Government welcomes the recommendation from the Commission on Race and Ethnic Disparities to improve the efficacy and consistency of de-escalation training[6], and we will consider this recommendation alongside the work that is already underway.

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[3] Page 9. JCHR (2021), Black people, racism and human rights: Government Response to the Committee's Eleventh Report of Session 2019-21

[4] Home Secretary at the Police Federation conference 2021 - GOV.UK (www.gov.uk)

[5] Home Office (2017) Deaths in police custody: A review of the international evidence

[6] Commission on Race and Ethnic Disparities (2021) – Commission on Race and Ethnic Disparities: The Report (recommendation 5, pg.17)

2.5. The NPCC and CoP have embedded risk assessments and best practice associated with restraint, positional asphyxia and acute behavioural disturbance (ABD) in national police training through the National Personal Safety Manual (NPSM) and the Authorised Professional Practice (APP) on Detention and Custody [7]. This was reinforced by the NPCC's '60 seconds to save a life' campaign' which has now been viewed over 10,000 times. The NPSM was updated in July 2020 to provide additional guidance on the risks to subjects during prolonged restraint. The NHS has also updated awareness on ABD.

2.6. The CoP has introduced a Safety Officer role into their NPSM who has specific responsibilities in situations where restraint is being used. The safety officer is responsible for monitoring the detainee's conditions, particularly the airway and response, and protecting and supporting the head and neck. Whilst this role is not specific to the custody environment the guidance applies within custody suites as it does to all front-line officers.

Custody Environment

2.7. Police custody plays a vital role in the justice process by protecting the public and enabling the effective investigation of criminal offences. Detainees in police custody are often the most vulnerable individuals in our society and the state owes them a significant duty of care.

2.8. HMICFRS have a rolling programme of inspection of custody provision and will inspect each force at least once every 6-7 years. Since April 2018, HMICFRS have conducted 16 custody inspections covering 16 forces. Inspections include in-depth reviews of cases involved intoxicated detainees and consider the use of liaison and diversion services, pre-release risk assessment and actions taken so that detainees can be released safely.

2.9. The National Police Estates Group (NPEG) developed, jointly with the Home Office and MoJ, the Police Buildings Design Guide for Custody in September 2019. The guide provides a design standard for forces to follow on building projects to deliver a safe and secure custodial environment which promotes the wellbeing of all users.

2.10. In January 2019, NPEG launched the Custody Review Panel (CRP), a peer review system for custody projects which enables professionals with custody related experience to review forces' design proposals and finished custody suites. Reviews highlight best practice and identify potential risks relating to ligature, self-harm and standard of finish. NPEG aims to embed sustained learning and support the delivery of safe and operationally efficient estates.

2.11. The use of body worn video (BWV) is a critical accountability tool that can capture police encounters. Police forces are now equipped with over 80,000 cameras[8]. Forces can monitor body worn video to make sure searches are carried out professionally and, in some cases, to monitor restraint when transporting detainees.

[7] ABD has been present in some recent deaths in or following police custody, such as the deaths of Kevin Clarke and Sheku Bayou.

[8] NPCC and Home Office figures (2020)

2.12. NHS England continues to provide national support and oversight to healthcare delivered in police custody suites and maintains the Police Custodial Healthcare Service Specification. This is used by all forces when tendering for new custodial services and is regularly reviewed by key stakeholders, including medical experts and police custody leads, in order to ensure that any policy or legislative changes are reflected. This delivers equity of care to everyone detained in police custody settings. Additionally, internal NHS health and justice leads, supported by NHS subject matter experts and a broad range of non-NHS clinicians, provide clinical oversight to the healthcare available in custody settings.

2.13. The CoP is currently developing a national training programme for officers looking at high risk custody themes scheduled for release in 2022. These modules focus on attitudinal and behavioural aspects of custody provision. The overriding aim is to ensure an individual approach is taken to each detainee to best manage their welfare and improve their overall custody experience. The scenarios identified in the programme reference many of the risks raised in the Review such as alcohol abuse, mental health concerns, female dignity and vulnerability.

2.14. The NPCC is leading work developing Custody Early Warning Scores (CEWs) to allow better identification of unwell detainees. CEWs are a reduced form of the mandatory National Early Warning Score used throughout the NHS across England. The NPCC Custody Risk Working Group are also investigating whether artificial intelligence or an algorithm can supplement the decision-making capabilities of custody officers.

Health and Wellbeing

2.15. The police often encounter people at a point of mental health crisis, and it is imperative that such people receive the response most appropriate to their medical needs as soon as possible. The best place for people suffering a mental health-related crisis is a healthcare setting, because the police cannot provide the specialist care needed and a police response may worsen the crisis.

2.16. Provisions contained in the Policing and Crime Act 2017, designed to improve outcomes for people in mental health crisis, came into effect on 11 December 2017. These include removing the use of police cells as places of safety for under 18s detained under section 135 or 136 of the Mental Health Act 1983, restricting the use of police cells for adults and reducing the maximum period of detention to 24 hours. Since then, there has been a general trend of reduction in the use of police cells as a place of safety and the regulations which detail when a police cell may be used has made it clear that these are only to be used in exceptional circumstances. The latest figures show continues encouraging progress; in 2019/20 a police station was used as a place of safety in 159 instances which is a 98% reduction since 2012/13.

2.17. The Mental Health White Paper published on 13 January 2021 responds to Sir Simon Wessely's Review of the Mental Health Act (applicable across England and Wales). The Home Office have accepted the majority of Sir Simon's recommendations regarding the role of policing and mental health services which will help ensure that people in crisis receive the right support. The White Paper focusses on a commitment to deliver long-term investment in the NHS and mental health services. This will focus on early intervention and

should deliver comprehensive crisis services which, in turn, should impact upon policing by providing alternative options to detention.

2.18. The Mental Health (Wales) Measure 2010 has already put proposals such as care plans for people subject to detention on a statutory footing in Wales. The Welsh Government has prioritised investment in mental health services in its recently published Programme for Government report. The Policing Partnership Board for Wales, chaired by the First Minister, agreed that mental health would be a top cross-cutting priority between the Welsh Government and Policing in Wales.

2.19. One of the measures in the White Paper is the desire to remove police stations as a place of safety for those in mental health crisis to ensure health staff will be available to identify any medical need and that cells are never considered as a first option. The White Paper additionally accepts the review's recommendation to improve ambulance provision for urgent mental health cases, which will significantly reduce the need for police vehicles to be used to transport someone.

2.20. All forces are currently using some form of street triage within their area, which aims to enable mental health professionals to work alongside the police, providing officers with 'real-time' information and advice to ensure people who need mental health support receive it as quickly as possible. The CoP, working with Nottingham University, has created a toolkit which has been adopted by the large majority of police forces and describes the steps a force should take in conjunction with strategic partners to evaluate the effectiveness of their respective street triage teams.

2.21. The Review noted that: '*liaison and diversion schemes can play an important role in ensuring that vulnerable people do not go into custody in the first place, especially if the need for medical care far outweighs the significance of the alleged offence*.' NHS England and NHS Improvement have rolled out Liaison and Diversion (L&D) services across England to ensure people who come into contact with the police and who have vulnerabilities such as substance misuse and/or mental health needs are identified, assessed and where appropriate referred on to support services rather than entering the criminal justice system.

2.22. The roll-out of NHS England and NHS Improvement-commissioned L&D services has placed clinical staff at police stations and courts across England to provide assessments and referrals to treatment and support. The NHS Long Term Plan, published in January 2019, committed to increased spending in services for people experiencing mental health crises which would help ease pressures on police services. This included continued funding of the NHS L&D service.

2.23. The Review highlighted deaths that have followed the use of restraint by police officers called to attend NHS mental health settings. The Mental Health Units (Use of Force) Act, also known as Seni's Law, increases the oversight and management of restraint in mental health units so that force is only ever used as a last resort. The Act requires units to produce policies and information for patients, keep a record of how and when force is used and improve staff training in prevention, de-escalation and the safe use of force. It also mandates police use of BWV if they are called to assist mental health staff in the use of force. It is essential that if things go wrong when force is used, it is properly investigated and that lessons are learned.

2.24. The NHS Long Term Plan for health services in England has committed to a dedicated national investment programme to improve the capacity and capability of the ambulance service to meet mental health demand including £70m additional revenue investment by 2023/24 for additional mental health professionals to deliver mental health specific initiatives and extra capacity in ambulance services. It includes commitments to provide more community mental health care, thus reducing the risk of people reaching crisis, and the rollout of Mental Health ambulances, so that people are not conveyed to health-based places of safety in police vehicles. Across Wales there is an ongoing pilot with St John's Ambulance aimed at improving services and reducing pressure on services relating to mental health transportation. In addition, Welsh police forces are engaging with executive leaders from across the seven university health boards focused on mental health provision, good practise and opportunities for improvement.

Funding for Families and Family Support

2.25. The Review highlighted the problems bereaved families experience in the immediate aftermath of a death and their experience of the subsequent inquest, including in receiving legal aid support.

2.26. In February 2019, the MoJ published its Final Report of the Review of Legal Aid for Inquests. This concluded that non-means tested legal aid for bereaved families to attend inquest hearings would not be introduced at this point. However, the evidence gathered as part of this review on financial eligibility will be considered as part of their wider Means Test Review, which will look at the thresholds and criteria for legal aid entitlement, including the means-testing position for families participating in inquests in relation to a death following police contact. This review will be published in autumn 2021. Currently, in circumstances where representation is appropriate, funding can be obtained through the Exceptional Case Funding (ECF) Scheme. The current ECF grant rate is 71%[9], the highest on record.

2.27. One of the Government's top priorities is ensuring that grieving families and friends who have lost loved ones are aware of, have access to and receive the support they need, when they need it. As a result of this, support and funding has been provided to charities and organisations who offer and signpost grieving friends and family members to tailored bereavement support. Part of this additional support and funding incudes £4.2m of additional funding to mental health charities and charities providing bereavement support which the Government announced in May 2020. DHSC are also investing £57m in suicide prevention and suicide bereavement support through the NHS Long Term Plan. The NHS Long Term Plan commits to designated suicide bereavement help in every area across the country by 2023/24.

Communications

2.28. Ensuring communications with families and the public regarding deaths in custody are as transparent as possible is critical to instilling trust and confidence in the end-to-end process for a death in custody.

[9] MoJ (2020), Legal aid statistics England and Wales bulletin Jul to Sep 2020

2.29. The IOPC has produced guidance, which is continually updated, for families and friends of someone who has died during or following contact with the police, including how it will communicate during the course of its investigation. The IOPC will also consult on news releases before release, where possible.

2.30. In June 2018 a protocol between the IOPC and NPCC was published, setting out the roles and responsibilities of police forces and the IOPC when communicating with the media and the public following a death in police custody. The protocol makes clear that the IOPC has the media lead on independent investigations and is responsible for releasing into the public domain information relevant to those investigations. However, it also allows forces to provide certain limited factual information publicly, both prior to and after the IOPC declaring an independent investigation. It states that, before an independent investigation is declared, forces should restrict their comments to matters of fact, which cannot become disputed during any IOPC investigation.

2.31. Together with the charity INQUEST, the Home Office, MoJ, IOPC, NPCC, and the Chief Coroner published a leaflet in December 2018 for families that sets out their rights, the roles of key organisations and the post-incident processes. In addition, the Home Office has developed an information leaflet for use in the immigration detention estate with details of available support for bereaved families. This leaflet is currently being translated into key languages to be more accessible.

2.32. We are working across different state custody settings and with partners to improve how to engage families after a death in custody, including through engaging in an exercise led by the IAPDC.

Investigations

2.33. Any death or serious injury that happens during or immediately following contact with the police must be referred to the IOPC for a decision whether to investigate and, if so, what form the investigation should take. The role of the IOPC is crucial in a system of police scrutiny and complaints that functions effectively and commands public confidence. There is a clear need for an independent body to oversee the police complaints system and investigate the most serious and sensitive cases involving the police.

2.34. The Government implemented a series of reforms to the IOPC in February 2020, as part of a wider overhaul of the police conduct and complaints regimes. The measures included the introduction of a new power to allow the IOPC to investigate on its own initiative immediately without the need to wait for a referral or having to “call in” referral from the police. It has also reduced reliance on policing by increasing funding to the IOPC to carry out more independent investigations and by abolishing the “managed” and “supervised” modes of investigation. Processes have been streamlined, including decision-making at the end of an investigation as to whether a case should be referred to a misconduct hearing, for example. To increase public confidence, the IOPC now has powers to present cases at disciplinary hearings in cases where it has investigated or directed an investigation in certain circumstances. The IOPC also has new powers to reopen cases it has closed, where there are compelling reasons to do so. From 1 February 2020 any complaints of misconduct or misconduct allegations against Chief Constables must now be

referred to the IOPC and the IOPC is required to investigate all such matters where there is an indication of misconduct.

2.35. The wider reforms to police complaints and discipline include adding a new "duty of cooperation" into the Police Standards of Professional Behaviour. This means that police officers now have a duty to cooperate with investigations, inquiries and formal proceedings when identified as a witness. Failure to do so is a breach of these standards and can be dealt with by forces accordingly. The measure should impact on the timing of the investigations of deaths and serious injuries, and conduct and complaints matters. The Government has also introduced new powers for the independent Legally Qualified Chairs of police misconduct hearings panels, including enabling them to hold pre-hearings, to provide for better management of the end to end process and to ensure they are completed in a timely manner.

2.36. There have been significant improvements in the timeliness of IOPC investigations since the reform of the Independent Police Complaints Commission (IPCC) as the IOPC was previously known. These governance reforms, implemented in January 2018, sought to increase accountability and streamline decision-making with a new single-head of decision-making rather than a Commission structure. Since the launch of the IOPC, over 90% of the IOPC's investigations are now completed within twelve months – an improvement on the track record of the IPCC, and some police forces' own complaints investigations. In 2019/20, the IOPC completed 79% of its independent investigations within 12 months maintaining the 79% achieved in 2018/19. The February 2020 reforms also require the IOPC and the police to give written explanations if cases take longer than 12 months to investigate, including on the progress of the investigation, an estimate of when the investigation report will be submitted and the reason for the length of time taken.

2.37. In 2019 the then Home Secretary, Rt Hon Sajid Javid MP, approved the IOPC Section 22 guidance to the police service on Achieving Best Evidence in Death or Serious Injury Matters. The guidance applies to the critical period after any death or serious injury following police contact, regardless of the circumstances. The approved guidance includes a preference that key police witnesses should be separated after an incident. The guidance strikes the balance between the operational needs of the police in exercising their duty to protect the public and the need for a transparent and robust investigation to preserve and promote public confidence; and is reflected in the CoP APP for armed policing and other death or serious injury matters. This APP provides detailed guidance in respect of the provision of witness accounts and conferring.

Coroners and Inquests

2.38. The Government is clear that inquests should be sympathetic to the needs of bereaved people. The MoJ has been undertaking a range of work focused on this.

2.39. On 28 January 2020, MoJ published its refreshed Guide to Coroners Services for Bereaved People, tailoring it to the needs of bereaved people. The Guide includes information on all aspects of the coronial process including viewing the body during the coroner's investigation, and sets out clearly, for bereaved families the post-mortem process and the rights of and role of the bereaved family. In 2019 the Chief Coroner also published guidance on Post-Mortem and Second Post-Mortem Examinations. The Guide

signposts families to other organisations that they may find helpful including seeking legal advice should they wish to and a range of bereavement and support organisations.

2.40. Within the revised Guide is a new protocol that sets out key principles for the Government and the lawyers it instructs when it has interested person status at inquests. The key principles include supporting an inquisitorial approach that assists the coroner to find the facts and learn lessons for the future and keep in mind that the bereaved should be at the heart of the inquest process. It will make sure that those involved in inquests as interested persons, witnesses, or coroners themselves are aware of the principles that Government and its lawyers will follow and can speak out if they feel standards are not being met.

2.41. Building on the protocol, the MoJ is supporting the legal services regulators in their work to develop inquest specific information for lawyers who practise in inquests such as a set of competencies they should meet, a toolkit to guide them and a conference for lawyers to hear first-hand the experiences of families in order to emphasise the importance of an inquisitorial approach.

2.42. The MoJ have also been working to help ensure families have a suitable area to wait during the inquest. Local authorities (LAs) have a statutory duty under Section 24 of the Coroners and Justice Act 2009 to provide suitable accommodation for bereaved families at coroners' inquests. It should be appropriate in terms of the dignity of the deceased and their families and therefore should include adequate private rooms for the family to use during the inquest. The Chief Coroner's revised Model Coroner Area, annexed to his Annual Report to the Lord Chancellor, was published in November 2020 which LAs are expected to adopt, although its provisions cannot be enforced.

2.43. Mandatory continuation training for all coroners delivered in 2019/20 addressed the vulnerability of bereaved people and witnesses, communication with families, the behaviour of counsel and general control of the court room. Alongside this, the 2019/20 training for coroners' officers – who engage more frequently with families during the inquest process – focused on language and dealing with vulnerable people.

2.44. Bereaved families have been involved in coroner training either directly or via organisations which support them. For example, in the 2019/20 training cycle, INQUEST led a session at all the coroners' officer training events.

2.45. The Chief Coroner has published revised guidance in 2020 on prevention of future death reports (PFDs) to assist with consistency of approach by coroners in their independent judicial decision-making.

2.46. MoJ considered the merits of establishing a National Coroner Service as suggested in the Review. It concluded, however, that a national organisation might not be appropriate and did not offer a cost-effective solution to address problems of the system. Instead, MoJ considered that preserving the benefits of a locally based service whilst introducing national leadership through a Chief Coroner was a better approach. Experience of the impact of the three Chief Coroners since 2013 supports this approach.

2.47. On 27 May 2021 the Justice Select Committee published its report 'The Coroner Service' following its enquiry into the Coroner Service. The report makes a range of recommendations to further improve coroner services and on the provision of legal aid at inquests. MoJ welcomes the report and will respond in due course.

Accountability

2.48. Accountability continues to be fundamental to the British model of policing by consent.

2.49. In February 2020, the Government introduced a tranche of reforms, further to those outlined in paragraph 2.36 to overhaul the police complaints and disciplinary systems, with new measures designed to improve transparency, accountability and proportionality. This includes an increase in the threshold for misconduct, so that now only serious breaches of the Standards of Professional Behaviour are dealt with under the disciplinary system, with lower-level matters handled locally by line managers under the new Reflective Practice Review Process. This helps focus the disciplinary system on serious breaches, whilst promoting and fostering a culture of learning and reflection for lower-level mistakes and under-performance. Serious breaches will continue to be investigated and referred to disciplinary proceedings and statutory guidance now also provides a presumption that when officers are found to have a case to answer for misconduct, they should be referred to disciplinary proceedings.

2.50. Legally Qualified Chairs (LQC) were introduced to chair hearings for gross misconduct allegations against police officers in January 2016, to provide an independent decision-maker for findings of gross misconduct and the appropriate sanctions. The CoP published the Guidance on Outcomes in April 2017 which is in the process of being updated to reflect the legislative changes introduced to police complaints and disciplinary systems in 2020. This Guidance supports those chairing disciplinary proceedings to make consistent decisions. The Guidance makes clear the threefold purpose of misconduct proceedings: to maintain public confidence; uphold high standards and protect the public. The Conduct Regulations require the Chair of misconduct proceedings to submit a report that includes the reason for the finding. In the case of a gross misconduct hearing this report must then be published to ensure a transparent process.

2.51. The Review highlights that delays in the end-to-end process often lead to distrust in the system. The MBDC considered the issue of wider delays in the system and the Home Office which has prompted work to reduce these delays in conjunction with the IOPC, the NPCC, the CPS and Chief Coroner's Office. The IOPC has developed more effective ways of working with the CPS, focussing on early advice and effective handover of cases following an investigation by the IOPC to support more timely decision-making. Similarly, the IOPC has developed a Memorandum of Understanding with the Chief Coroner aimed at a more efficient way of working.

2.52. As part of the Government's reforms to the police complaints and disciplinary systems, provisions governing the timeliness of investigations were introduced. Since February 2020, where an investigation is not concluded within 12 months, the investigating body must set out a written explanation of the progress of the investigation, an estimate of when the final report of the investigation will be submitted, the reason for the length of time being taken to complete the investigation and a summary of planned steps to progress the investigation and bring it to a conclusion.

Training

2.53. Training is continually evolving to tackle emerging issues and it is imperative that those who are conducting investigations, or encountering members of the public, are aware of the local policing context and the needs of communities.

2.54. The IOPC has recently agreed a proposal about how to better support bereaved families. This will form part of future design work and includes consideration of how to collect feedback from families. The IOPC has also developed a bespoke Family Liaison Manager training course, which has been created using feedback from families and service users. In March 2020, the IOPC achieved Customer Service Excellence accreditations scoring particularly highly on focus on service users, work with hard to reach and disadvantaged people and learning being a continued focus.

2.55. The Review suggested that the IPCC should '*ensure that race and discrimination issues are considered as an integral part of its work'*. The IOPC have expanded their programme of discrimination training for operational staff. Since August 2020, more than 70 investigative staff and casework managers have been trained nationally to lead and support race discrimination work. The training is designed to improve technical knowledge and covers the overarching principles and practicalities of investigating race-based discrimination.

2.56. The Review wanted to ensure that national policing bodies and police forces confronted discriminatory assumptions and stereotypes as part of training. The CoP has developed a national curriculum on stop and search, meaning the training that forces deliver to their front-line police officers and their supervisors on the fair and effective use of their powers is required to meet the College's learning standards. The curriculum covers the historical context of the relationship between the police and minority groups (including the Lawrence Inquiry) and practical skills (including how to manage encounters and identify and challenge biased decision-making). These are also addressed in the curriculum for new recruits as part of the Police Education and Qualifications Framework.

2.57. The Review acknowledged the importance of well formulated and consistently applied pre-release risk assessments. The CoP Detention and Custody APP contains a section titled 'release from custody' which articulates the practical steps required to provide support and protection to those assessed as being at risk of self-harm. The pre-release risk assessment is developed throughout a detainee's period in custody and includes specific conversations with the detainee. This has been updated in June 2019 providing guidance on managing the suicide risk for suspects of indecent images of children offences.

2.58. The CoP has worked with the NPCC and National Crime Agency (NCA) to develop briefing products for officers regarding the increased risk of self-harm and suicide presented by people arrested for possession of indecent images of children. In March 2020, the assessment was updated to include consideration of the risk of exploitation faced by vulnerable detainees associated with county lines after their release from custody in response to an HMICFRS recommendation.

2.59. The Review highlighted that that vulnerable women in police custody may experience unique difficulties and noted that the police and healthcare providers should take that into account. The CoP Detention and Custody APP provides guidance on the requirements of female detainees. This has been updated to reflect the needs of menstruating detainees in

line with the revisions to PACE Codes of Practice C and H in August 2019 which ensured that female detainees had access to sufficient sanitary protection and washing and changing facilities.

2.60. The CoP published a Mental Health APP in 2016 which highlights the actions and behaviours that may help the police address the needs of mentally vulnerable individuals. The APP is complemented by an e-learning introduction as well as the Mental Health and Learning Disabilities Trainer Guide to assist forces in designing material to tailor the training to suit various roles.

Learning

2.61. One of the key themes to emerge from the Review was the failure of agencies to learn lessons from deaths in custody. Training and guidance is heavily influenced by learning from deaths, and the Government will continue to lead conversations on how the collation and dissemination of learning across coroners, inspectorates, watchdogs and the MBDC can be improved.

2.62. The Review recommended the creation of an Office for Article 2 Compliance. As the Government made clear in its response to the Review in 2017, we do not consider that a new and distinct Commissioner or Office for Article 2 Compliance is the most effective means of driving compliance with Article 2 of the European Convention on Human Rights (ECHR). This is referenced in the Government's recent response to the JCHR report into 'Black people, racism and human rights', which also explains how agencies already work together to learn lessons from deaths.

2.63. Existing agencies have a role to play here and their collation and dissemination of learning in this area must be made more effective, rather than duplicating this function in a separate Office for Article 2 Compliance. Coroners, inspectorates, independent watchdogs (such as the IOPC) and the MBDC are working towards strengthening their collaboration in this regard, and the Government will lead conversations as to how this is best achieved.

2.64. Since 2018, the IOPC has begun a more thematic approach to improve the quality and consistency of its investigative work, including creating Subject Matter Networks (SMNs) in key thematic areas including mental health, discrimination, deaths in custody and use of force. These are networks of experts who can provide advice and guidance to investigators. This thematic approach will assist the IOPC to develop a body of evidence for learning and prevention work. As part of its custody inspections HMICFRS works with the IOPC to assess progress against any recommendations that the IOPC may have made to a force following an investigation.

2.65. Departments and agencies have systems in place to consider and respond to PFDs, which are issued when a coroner believes operations or policies highlighted in an investigation or inquest could be reviewed or changed to save lives in the future. However, more is being done to ensure responses are robust and learning is shared beyond the named recipient of the reports including central analysis to identify recurrent themes and facilitate cross-sector learning.

Statistics

2.66. The national collection of use of force data since 2017 and the publication of national use of force data since 2018 has significantly increased transparency and accountability in this area. In the longer term, as data quality improves, it will also provide an evidence base to support the development of tactics, training and equipment to enhance the safety of all. In addition, individual forces are expected to conduct their own analysis of their data collections to identify patterns and trends in data, develop ways of improving practice and test the impact of local initiatives. The Home Office will continue to work with the NPCC and other stakeholders to keep the scope of the data collection under review and will make changes to the collection where we identify appropriate opportunities to improve and refine it.

2.67. All deaths and serious injuries, including those following use of force, must be referred to the IOPC for a decision whether to investigate and, if so, the form the investigation should take. The IOPC publishes annual statistics on deaths following police contact, including a break down by age, ethnicity and gender. In 2019/20, as well as providing a description for all 'other deaths following police contact' cases that involved police use of force, the IOPC have published a summary slide deck that clearly outlines the main figures from this year's report in order to increase clarity and accessibility to the public.

2.68. There will be mandatory ethnic monitoring of Gypsy Roma and Traveller groups in England and Wales by police forces in their ethnic monitoring systems from April 2021 which will help get a better understanding of the representation of traveller groups in police custody.

Research

2.69. Less lethal weapons, including Taser, undergo robust testing and monitoring. Assessments of the safety of Conducted Energy Devices, such as Taser, for police use are formally undertaken by an independent medical committee (SACMILL)[10] that advises government of its findings before any device can be approved for use in the UK. This follows comprehensive testing on the performance of the device by the Defence Science and Technology Laboratory.

2.70. On 1 September 2020 the NPCC announced an Independent Review of Taser as part of their Officer Safety Review. The review launched in January of this year with Junior Smart OBE announced as Panel Chair of the review on 17 December 2020. The project will run for an initial period of around 12 months and will examine the causes and consequences of racial disparities in police use of Taser with the aim of providing an evidence base to identify changes which could improve racial disparities in Taser use. Findings will be published throughout the course of the review.

[10] Scientific Advisory Committee on the Medical Implications of Less-Lethal Weapons (SACMILL) is a non-departmental public body that provides independent advice to Ministers of Her Majesty's Government. This advice concerns the medical aspects surrounding the use by the police and other authorised bodies of less-lethal weapons (LLWs) on members of the public.

3. Next Steps

3.1. Dame Elish's Review has driven the cross-agency work programme for preventing deaths in custody and supporting bereaved families since its publication. The co-chairs of the MBDC and all associated agencies are committed to sustaining momentum to prevent further deaths in custody. The MBDC will continue to provide periodic progress updates on its work programme to prevent deaths in all forms of state custody.

3.2. Future work areas to further prevent deaths in police custody will be guided by the Policing Minister, in consultation with the MBDC and IAPDC, to build on key themes and address emerging ways to prevent further deaths in or following police custody. This will include, but may not be limited to, the following themes:

3.2.1. **Mental Health**. It is crucial that those suffering from mental health-related crises receive the response most appropriate to their needs as soon as possible and that appropriate health and social services are available. The Mental Health Act White Paper commits to removing police stations as a place of safety when there are sufficient alternatives in place, for those in mental health crisis to be taken to a health-based place of safety. The white paper additionally accepts the need to improve ambulance provision for urgent mental health cases, which will significantly reduce incidences of conveyancing by police vehicle.

3.2.2. **Disparities**. The causes of racial disparities are complex and reflect broader social inequalities. We know that black men are over-represented within the criminal justice system and therefore recognise the importance of ensuring that everyone has confidence in the police and other agencies. We need to improve data collection to fully understand the extent to which race and ethnicity impact detainees' experiences and the use of police powers within police custody and use this to enable a more informed response to concerns about ethnic disparities.

3.2.3. **Embedding Learning.** Ensuring forces learn lessons after a death in custody is vital, especially for bereaved families who repeatedly make clear their wish that no other family should go through the same experience as they have. We are currently assessing how PFDs issued by coroners are understood and responded to across custodial agencies. Government departments will continue to work closely with the IOPC and HMICFRS to embed lessons learned as quickly as possible after deaths or serious incidents in or following police custody.

3.2.4. **Post-Custody Suicides**. There were 54 apparent suicides following police custody in 2019/20, a figure significantly higher than the recorded number of deaths in or following police custody. We consider that there may be opportunities to understand more about those individuals who pose the highest risk of post-release suicide and how pre-release assessments may further identify early warning signs of behaviour linked to risk of suicide.

3.3. We recognise there is still work to be done to reduce deaths in custody as far as possible. Government departments and partner agencies recognise the momentum provided by the Review and will continue to learn lessons and improve practices. Further updates will be provided by departments as necessary on ongoing and emerging themes.