



HM Government

Deaths in Police Custody: Progress Update

December 2018

Deaths in police custody: progress update

On 30 October 2017, the Rt Hon Dame Elish Angiolini DBE QC's *Independent Review of Deaths and Serious Incidents in Police Custody* was published, alongside the Government's substantive response.

As part of its response, the Government commissioned the Ministerial Council on Deaths in Custody to play a leading role in considering the most complex of Dame Elish's recommendations. This update sets out progress made in delivering the work programme of the Ministerial Board on Deaths in Custody which is co-chaired by the Rt Hon Nick Hurd MP, Rory Stewart OBE MP and Jackie Doyle-Price MP.

We have made good progress although there remains more to do. First, we have focused on support for families, which includes work on the provision of legal aid for bereaved families, making inquests more sympathetic to their needs and improving the information available immediately after an incident. Second, we have worked to ensure that organisations are held to account when a death in police custody occurs. We have reformed the Independent Office for Police Conduct (IOPC) to strengthen its independence and improve the timeliness of its investigations, and we have introduced reforms to strengthen the police discipline regime. Third, we highlight work undertaken to prevent deaths in police custody, such as restricting the use of police stations as places of safety, the National Police Chiefs' Council's (NPCC) work on national training and assessing the health of detainees, as well as significant investment in mental health.

Supporting families

Dame Elish's comprehensive review was particularly valuable in affording a central role to the perspectives of bereaved families, and demonstrating the rich source of learning that they offer. In driving forward the work programme, we have endeavored to keep families at the heart of the changes we are delivering. On 13 June, the Ministry of Justice (MoJ) published revised exceptional case funding guidance for legal aid. The revised guidance makes a clear starting presumption that legal aid should be awarded for representation of the bereaved at an inquest following the non-natural death or suicide of a person detained by police or in prison. Furthermore, the MoJ is currently reviewing the provision of legal aid for inquests. The review looks at what is needed to ensure that bereaved people can understand and properly participate in inquest proceedings. To inform this review, MoJ undertook a public call for evidence which closed in August.

To make inquests more sympathetic to the needs of bereaved families and ensure that advocates bring the right approach to inquests, the MoJ are developing a protocol that sets out key principles for public bodies and their legal representatives to follow. These include a commitment to: supporting an inquisitorial, rather than adversarial, approach; maintaining openness and transparency in communicating with bereaved families; communicating with bereaved families in a sensitive and empathetic way which respects their loss; offering an early apology where appropriate; and giving consideration to reducing numbers of lawyers.

Under the direction of the Chief Coroner, next year's mandatory two-day training for all coroners will address the vulnerability of bereaved people and witnesses, communication with families, the behaviour of counsel and general control of the court room. Alongside this, next year's training for coroners' officers – who engage more frequently with families during the inquest process – will focus on language and dealing with vulnerable people.

The MoJ is also considering extending support services for coroners' inquests to all coroners' courts, subject to affordability. These support services currently exist in 43 of the 88 coroner areas and they provide practical and emotional support to bereaved families when they attend inquests.

Dame Elish's review also stressed the need to improve the immediate information that is provided to families following the deaths of their loved one. Together with INQUEST, a charity that provides expertise on state related deaths to bereaved people, the Home Office, MoJ, IOPC, NPCC, and the Chief Coroner have developed a leaflet for families that sets out their rights, the roles of key organisations and the post-incident processes. The leaflet is being published today on Gov.uk.

Strengthening accountability

It is essential that when deaths and serious incidents in police custody do occur, they are investigated thoroughly, agencies and individuals are held to account and lessons are learned. In January, the Home Office launched the Independent Office of Police Conduct, to replace the Independent Police Complaints Commission. The old Commission structure was replaced with a new Director General, Michael Lockwood, as the single head of decision-making to streamline processes. The average time taken to conclude investigations has reduced from 294 days in 2014/15 to 223 days in 2017/18. In 2017/18, the IOPC closed more investigations (709) than they opened (705) for the first time since the rapid expansion of the number of cases they investigate.

The Home Office is working to implement further reforms next year. These include: a new legal requirement on the IOPC to explain, and propose next steps, where investigations take longer than 12 months; a duty of co-operation under Professional Standards of Behaviour for police officers to participate openly and professionally in line with expectations when identified as a witness; and new powers for the IOPC to reopen an investigation it has closed, without undergoing costly judicial review processes as happens now, and to investigate matters without having to wait for referral by the police.

This country is proud to have world-leading police forces. The police put themselves in harm's way to protect the public with honesty and integrity. Police integrity and accountability are central to public confidence in policing and the Government must ensure the public have confidence in the police to serve our communities and keep us safe. When things go wrong, swift action is needed to expose and tackle any misconduct. Action must be open, fair and robust. This is why the Home Office implemented legislation in January to prevent anyone who has previously served as a police officer from being appointed the Director General of the IOPC, and to allow the Director General to decide which roles within the IOPC are barred to former police officers.

We have also extended the disciplinary system to former officers so that, where serious wrongdoing is alleged, an investigation and subsequent disciplinary proceedings can continue until their conclusion, even when an officer has left the force. We have made publicly available a statutory Police Barred List of officers, special constables and staff who have been dismissed from the force and are barred from policing. The Home Office is working to implement further reforms next year to strengthen the police discipline regime, including a requirement for all investigations into disciplinary matters involving chief officers to be conducted by the IOPC.

Preventing deaths

Above all, we are committed to doing all we can to prevent deaths in police custody. The latest statistics are clear evidence that we cannot be complacent and must keep striving to prevent deaths. The Home Office has strengthened safeguards in the custody environment and it is now unlawful to use a police station as a place of safety for anyone under 18 years of age in any circumstance, and we have significantly restricted the circumstances in which they may be used for

those aged 18 and over who are experiencing a mental health crisis and have committed no offence. The NPCC are trialling a system to monitor and assess the health of detainees, and they are working with the College of Policing to improve consistency in how national custody training is delivered in each police force.

Mental health is a significant contributing factor to deaths in police custody. The Government is investing record levels in mental health with planned expenditure of almost £12 billion in 2017/18. NHS clinical commissioning groups are required to increase their spending each year in line with the growth in their overall funding allocations. The Independent Review of the Mental Health Act, published on 6 December, provides recommendations for change, and through the Five Year Forward View for Mental Health, funding of £25m became available in April for suicide prevention to support local areas to embed their plans and a national quality improvement programme to improve the safety on mental health wards, including an ambition for zero suicides in mental health inpatients. The Prime Minister announced the UK's first Minister for Suicide Prevention in October to drive this agenda. The Department of Health and Social Care will also be looking at how lessons are learned nationally and disseminated where coroners provide Prevention of Future deaths reports following the death of someone detained by the state.

Dame Elish's report has been a catalyst for change, and the Ministerial Board on Deaths in Custody is committed to sustaining momentum in addressing the difficult issues at hand. We will deliver a Year 2 work programme, which will continue to prioritise preventing deaths in custody, and in the tragic situations that they do occur, holding organisations to account and improving support for families.



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