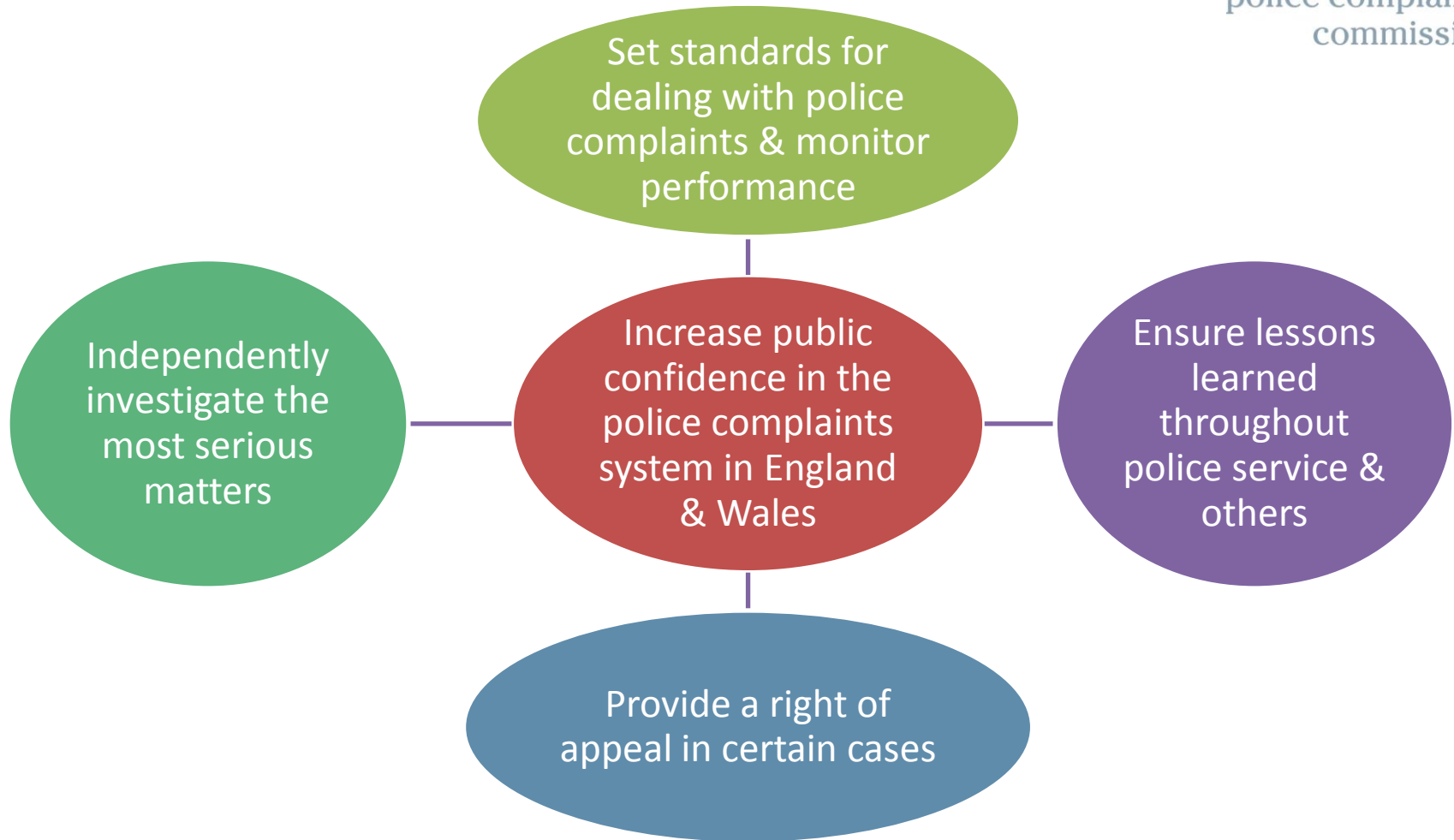


Preventing Deaths in Police Care

Working together to improve care in police custody

Sarah Green
IPCC Commissioner

IPCC Role



IPCC Role in Improving Care of Detainees



- Conduct or oversee investigations
- Consider appeals re: complaints in some cases
- Identify learning, and ensure this is reflected in police guidance and training
- Produce annual statistics on deaths, and research
- Work with others to ensure changes are implemented

IPCC Investigations

- Police have a statutory duty to refer deaths and serious injuries to IPCC in all cases
- Cases meeting the mandatory referral criteria must also be referred
- Forces may also make voluntary referrals
- IPCC has power to call in cases

Article 2 Investigations

- Right to life
- Deaths that occur during or following police contact may breach Article 2
- IPCC will begin independent investigations into all cases which engage Article 2 – this includes all custody deaths, and some deaths following police contact
- If becomes clear Article 2 not engaged may re-determine mode of investigation

Requirements of Article 2 Investigations

- Independent
- Subject to public scrutiny
- Prompt
- Effective
- Engaged with next of kin

Independent Investigations

Initial actions by IPCC:

- Deploy staff to scheme to handle the initial stages of the investigation – provide guidance over the phone to the force
- Consider whether any potential criminal or conduct issues
- Gather evidence
- Attend post-incident management procedures
- Liaise with external parties e.g. Coroner, HSE
- Handle media
- Contact family and explain role

Independent Investigations

Initial actions – force

- Secure scene and exhibits (under IPCC instruction)
- Carry out PIM procedures that support officers and facilitate the giving of accounts about the incident

Investigation by IPCC

- Set terms of reference
- Collect and analyse evidence including witness interviews
- Consider use of experts
- Engage with family and communities
- Provide updates to families and other interested parties inc Coroner
- Attend pre-inquest hearings

Final Report

At end of investigation IPCC produces a report which will set out:

- Conduct issues
- Criminal issues
- National and/or local learning recommendations

Learning from Investigations



IPCC learning has been reflected in:

- 2012 Safer Detention Guidance
- Changes to PACE

IPCC Learning & Safer Detention

- Intoxication changed to drunk and incapable
- Restraint techniques used during arrest or transportation should be explained by the arresting officer before a risk assessment is completed, and any effects caused by restraint may indicate a need for medical attention

IPCC Learning Reflected in Safer Detention Guidance

- Contract staff working in custody must be fully aware of their role and be trained
- Staff working in custody suite should receive training and refresher training in first aid
- If a detainee cannot be roused, they should be immediately treated as a medical emergency

IPCC Learning and Safer Detention

- Individuals who have consumed alcohol and drugs should be risk assessed on arrival and throughout detention, and unwillingness and inability to participate in risk assessment is a possible warning of risk. Cell visits and checks must be completed at appropriate intervals.
- Symptoms of serious illness or injury may go unnoticed in individuals who are well known or familiar to police officers
- CCTV should be available in at least one cell to be used when a detainee is identified as being at risk
- Independent custody visitors should ensure CCTV is operational

IPCC Learning Reflected in Safer Detention guidance

- Cell buzzers, intercoms and lights must be checked
- If there is more than one custody officer, need clarity about who is designated Custody Officer
- Handovers should be done verbally within sight and sound of CCTV -written acknowledgement of handover should be made on the custody record
- Custody manager should ensure that healthcare professionals working within their force are aware of local procedures
- Health care professionals should write their directions on frequency of checks and rousing in the custody record

IPCC Learning Reflected in PACE

PACE Codes C and H

- Intoxicated has been replaced with under the influence
- Improper treatment should be reported to the custody officer
- Any actions carried out by custody staff the outcomes should be reported to the Custody Officer
- Those who the Custody Officer delegates tasks to must be trained and competent

Implementation of Recommendations

- Continue to work with ACPO and College of Policing to ensure national recommendations are reflected in guidance
- Feed into HMIC/HMIP custody inspections
- Seeking new powers to require forces to respond to learning recommendations
- Working with PCCs to ensure recommendations are implemented

IPCC Statistics & Research



- IPCC produces an annual report on deaths following police contact
- Longer term study published 2010
- Subject to increase in funding, will conduct further research in future

Deaths Trend Data - 2004/05 to 2012/13

Category	Fatalities								
	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13
Deaths in or following police custody	36	28	27	22	15	17	21	15	15
Apparent suicides following custody	46	40	47	45	56	54	46	39	64

Deaths in or Following Police Custody 2012/13

- 14 men and one woman died in police custody
- 12 White British, two “Other” White, one White & Black African ethnic origin
- Four were known to have been restrained by police officers at some point prior to their death
- Nine people had a link to alcohol and drugs
- Mental health continued to be a key factor in almost half the deaths

Deaths in or Following Police Custody: Cause of Death, 12/13

Cause of death	Number of fatalities
Heart disease / cardiac arrest	2
Asphyxiation*	2
Multiple injuries	1
Drug / alcohol overdose	1
Gun shot wound	1
Long-term illness	1
Inconclusive	2
Awaited	5
Total fatalities	15

Deaths During or Following Police Contact - 2012/13

- Considerable rise in number of suicides following release from custody
- Mental health continued to be a key factor in deaths (two-thirds of cases)

Apparent Suicides Following Police Custody: Reason for Detention, 12/13

Reason for detention	Number of fatalities
Sexual offences	18
Violence related (non sexual) / threatening behaviour / harassment	17
Driving offence, including drink driving	8
Detained under the Mental Health Act	7
Theft / shoplifting	5
Breach of peace / public order / criminal damage	4
Drug / alcohol related (exc. drink driving)	2
Breach of bail / orders	2
Other	1
Total fatalities	64

Incidents by Type of Death and Investigation Type, 12/13

Type of investigation	Deaths in or following police custody		Apparent suicides following custody	
	N	%	N	%
Independent	9	60	4	6
Managed	0	-	0	-
Supervised	0	-	0	-
Local	6	40	15	23
Back to force	0	-	45	70
Total incidents	15	100	64	100

Current Areas of Concern/Potential Risk

- Care of pregnant detainees
- Care young people – appropriate adult
- Places of Safety under Section 136 of the Mental Health Act
- Use of tasers within custody – not as pain compliance
- Emergency Response Belt (ERB) as a spit/bite hood.

Review of IPCC's Work in Investigating Deaths

Aim of the Review

To identify and implement changes to ensure that our work in investigating deaths is:

- thorough, transparent and effective
- sensitive to the needs and expectations of bereaved families
- able to build and sustain public confidence

Emerging Findings

Progress Report published September 2013

Main themes:

- Independence of the IPCC
- IPCC engagement with bereaved families
- Effectiveness of IPCC investigations

Independence

Feedback

- IPCC too close to the police and police too involved in our investigations

Action

- Diversifying our work force
- Strengthening role of Commissioner
- Clear directions at the scene and will publish our expectations

Future

- Expanded IPCC – ex police will not investigate previous force
- More internal specialists
- External experts

Engaging with Families

Feedback

- Lack of sensitivity
- Lack of involvement and information given

Action

- Training to ensure sensitivity and that we meet needs
- Meeting Commissioner and contact with manager
- Revised leaflets
- Provide opportunity to comment on terms of reference, press releases and given meaningful updates

Future

- Work with INQUEST
- Revise approach to family liaison

Effectiveness

Feedback

- Should investigate all deaths
- Consistent, transparent and timely in decision making

Action

- Any death where there may have been a breach of Art.2 independently investigated
- Publish criteria of how make decisions
- Pilot specific MOI unit

Effectiveness

Feedback

- Some new powers but not enough, and need to be more robust in using them

Action

- Seeking further powers
- Expect officers to be separated and to not confer
- Will continue to use our powers to arrest and interview under criminal caution on a case-by-case basis

Effectiveness

Feedback

- Investigations take too long
- Quality variable
- Lack robust analysis of evidence and sufficient challenge of police accounts

Action

- Reviewing investigations directorate
- Further training
- Improve quality assurance

Effectiveness

Feedback

- IPCC should have a greater role in discipline
- Enforce recommendations
- Build on learning the lessons and thematic work to share good practice

Action

- Power to require response to recommendations
- More independence and transparency in discipline system
- Share findings of work with other bodies

Learning the Lessons

- The IPCC publishes a regular bulletin to help the police service learn lessons from investigations and other operations of the police complaints and conduct system.
- Bulletin 16 covers custody



Any Questions ?

