Independent Advisory Panel on Deaths in Custody response to the Home Office Review of investigatory arrangements which follow police use of force and police driving incidents – November 2023

1. The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to provide independent advice and expertise to Ministers and officials with the central aim of preventing deaths in custody and ensuring Ministers meet their human rights obligations to protect life.

Introduction

2. The IAPDC welcomes the opportunity to respond to the Home Office's review of investigatory arrangements which follow police use of force and police driving incidents. While the review clearly includes issues extending beyond the Panel's remit, the framework of laws and guidance "*that underpin police use of force and police driving, and the subsequent framework for investigation of any incidents that may occur"* under consideration in the Review is by and large the same framework which operates to prevent deaths in police custody. Our submission seeks to draw attention to some of the wider implications of any changes to this framework, and also addresses "*whether necessary lessons have previously been understood and acted upon after historic incidents*".[1]

3. The Ministerial Board on Deaths in Custody (of which the IAPDC forms part) has responsibility for overseeing the implementation of the recommendations of Dame Angiolini DBE KC's Independent Review of Deaths and Serious Incidents in Police Custody.[2] The Angiolini Review made many findings and recommendations relevant to the present Home Office Review, which the Government has committed to implementing[3] pursuant to its *"zero-tolerance attitude*" towards deaths in police custody.[4] This stance is critical to effective Home Office leadership on preventing deaths in police custody and it is vital that this commitment is reaffirmed. This is especially important given that the 2022/2023 reporting period saw a significant rise in the number of deaths during or following police custody – 23 deaths in 2022/23, an increase of 12 from 2021/22 and the highest figure since 2017/18. Of these deaths, 11 were identified by the IOPC as involving the use of force.[5]

4. We also wish to note that the timeframe for responses to this consultation has been short, bearing in mind the breadth of the Review. This has impacted what the IAPDC has been able to address in this submission, and it may overall impact the Review's reception of high-quality and meaningful responses from those consulted.

Summary

5. This submission focuses on the following key issues:

    a. The UK's obligations under Article 2 of the European Convention on Human Rights (ECHR), including where there is evidence that discriminatory attitudes played a part in a death;

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[1] Home Office, 'Review of investigatory arrangements which follow police use of force and police driving related incidents: terms of reference', November 2023, available here.
[2] Dame Elish Angiolini DBE KC, 'The Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, available here.
[3] HM Government 'Government response to the Independent Review of Deaths and Serious Incidents in Police Custody', October 2017, available here.
[4] DHSC, Home Office, MoJ, 'Deaths in police custody: progress update 2021', July 2021, available here.
[5] IOPC, 'Deaths During or Following Police Contact, Statistics for England and Wales 2022/23', 28 July 2023, available here.

b. The vital need to prevent restraint deaths, particularly of those experiencing a mental health crisis, such as Acute Behavioural Disturbance (ABD);
c. The issue of racial disparities in the use of force and deaths in custody; and
d. The conditions necessary to ensure prompt, effective and robust investigations and lesson learning, to maintain public confidence in policing.

The UK's obligations under Article 2 ECHR

6. The right to life in Article 2 ECHR imposes a number of obligations relevant to the issues within the scope of the Review. The State must ensure that lethal force – which includes unintentionally lethal force such as in a case of fatal restraint – is limited to that which is absolutely necessary. Where there is an alleged breach of the Article 2 prohibition on the use of lethal force, an investigative duty arises requiring an effective official investigation and a response adequate to properly implement the domestic framework, punish breaches, and deter future breaches.

7. Where a death has been inflicted at the hands of a State agent, particularly stringent scrutiny is required in the investigation. The investigation must satisfy a number of minimum standards, including being independent from those implicated in the events, taking all reasonable steps to secure all relevant evidence, involvement of the victim's family to the extent necessary to safeguard their legitimate interests, a sufficient element of public scrutiny of the investigation, and reasonable promptness and expedition of the investigation.[6]

8. Where there is a basis to suspect that discriminatory attitudes played a part in the death, the investigating authorities are under an additional duty to take all reasonable steps to investigate whether this was in fact the case. Failing to do so would potentially violate both the Article 2 investigative duty and Article 14 which prohibits discrimination in the enjoyment of other Convention rights.[7]

9. The purposes of the Article 2 investigative duty include rectifying dangerous practices and procedures, such as by enhancing the domestic system of safeguards applicable to the use of force. This ensures that those who have lost their relatives at least have the satisfaction of knowing that lessons learned from these deaths may save the lives of others.[8]

Restraint deaths and mental health

10. The Angiolini Review identified police restraint deaths as one of the most serious categories of deaths in custody and highlighted that many of those who die following the use of physical restraint suffer from mental ill-health. The review made a series of important recommendations regarding use of force to reduce restraint deaths in custody.[9]

11. Restraint deaths remain a significant cause of concern, particularly deaths involving people experiencing mental ill-health. For example, of the 23 deaths in or following police custody in 2022/23, 11 involved the use of force, with 10 individuals being physically restrained.[10] Further, 6 of the deaths falling within the IOPC's 'other deaths'

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[6] See *Nachova and Others v. Bulgaria* [GC], 2005, at [93]-[97] available here and *Armani Da Silva v. the United Kingdom* [GC] 2016, [229]-[239], available here.
[7] See *Nachova and Others v. Bulgaria* [GC], 2005, at [160]-[161] available here.
[8] See *R(Amin) v Secretary of State for the Home Department* [2003] UKHL 51 at [31] per Lord Bingham, available here.
[9] Dame Elish Angiolini DBE KC, 'The Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, Chapters 2 and 4, available here.
[10] Though the IOPC note that this does not mean that the use of restraint, or other types of force, necessarily contributed to the deaths.

category – where individuals were not arrested nor detained but the IOPC nonetheless conducted an investigation – involved the use of force and 5 individuals were physically restrained. In 13 of the 23 deaths recorded as being deaths in or following custody, the deceased person was known to be suffering from mental health issues.[11]

12. The Review should ensure that this category of cases is kept firmly in mind. It specifically asks "*whether necessary lessons have previously been understood and acted upon after historic incidents*" and whether "*the framework [for use of force] is sufficient to maintain public confidence in policing*". Restraint deaths, particularly involving persons suffering from a mental health crisis, are a category where tragically preventable deaths in custody continue to occur due to slow progress in learning and embedding the lessons from previous deaths. This serves to undermine public confidence in policing. Recent examples include the failures found in the inquests into the deaths of Neal Saunders and Kevin Clarke, which concerned men suffering from ABD.[12]

13. The Angiolini Review also found that rates of deaths following use of restraint was disproportionately high for persons of Black and other minority ethnicity compared to white people and drew attention to concerns around the risk of "double discrimination" experienced by Black people with mental health issues.[13]

14. It is right to note that progress has been made in meeting a number of the Angiolini Review's recommendations in this area.[14] This includes, for example, the new custody training package produced by the College of Policing, which the IAPDC understands is being rolled out across the country.[15] It also includes the establishment of Liaison and Diversion services and street triage schemes, although in a recent report the IAPDC found that there remains significant variance between police force areas.[16] Meanwhile, the 'Right Care, Right Person' model has the potential to both improve safety and free up significant police resources.[17] However, there are clearly great challenges in safely rolling out this model.[18] These are all substantial issues relating to police use of force with significant implications for preventing deaths in custody and confidence in policing, which the IAPDC urges the Home Office to prioritise.

Racial disparities in use of force and deaths in custody

15. The Angiolini Review found 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.*"[19] Some six years on, Baroness Casey's Independent review into the standards of behaviour and internal culture of the Metropolitan Police

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[11] IOPC, 'Deaths During or Following Police Contact, Statistics for England and Wales 2022/23', 28 July 2023, available here.
[12] Neal Saunders, Preventing Future Death Report, published 15 December 2022, available here. Kevin Clarke, Preventing Future Death Report, published 18 February 2021, available here.
[13] Dame Elish Angiolini DBE KC, 'The Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, paras 1.36 and 5.18-5.27, available here.
[14] Home Office, 'Government update on action taken to prevent deaths in custody' July 2021, available here.
[15] IAPDC, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', December 2022, para. 53, available here.
[16] *Ibid.*
[17] DHSC, Home Office, MoJ, 'Deaths in police custody: progress update 2021', July 2021, available here.
[18] IAPDC, 'IAPDC responds to the National Partnership Agreement', July 2023, available here.
[19] Dame Elish Angiolini DBE KC, 'The Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, para. 5.6, available here.

Service found that "*Black Londoners in particular remain over-policed. They are more likely to be stopped and searched, handcuffed, batoned and Tasered, are overrepresented in many serious crimes, and when they are victims of crime, they are less satisfied with the service they receive than other Londoners. There is now generational mistrust of the police among Black Londoners*."[20] The Casey Review also drew attention to evidence of discrimination against persons with other protected characteristics, such as misogyny and homophobia.

16. The latest Home Office Police use of force statistics published in December 2022 show that people perceived as Black experienced the use of force at three times the rate as those perceived as white.[21] There has been some debate regarding the extent to which the available data supports the existence of racial disparity in the rates of death following police use of force. While acknowledging racial disparities across the justice system, the Government has previously argued that the data does not support a higher rate of death for Black men.[22]

17. However, as already noted above, the Angiolini Review found "evidence of disproportionate deaths of BAME people" where restraint was used.[23] Further, a recent report by the charity INQUEST argues that once a wider range of data is taken into account, Black people may be in the region of seven times more likely to die following the use of police restraint as compared to white people.[24] While the data in this area is complex, such concerns need to be addressed. In the IAPDC's view, carefully analysing and drawing themes from the full available data (and improving the quality of the data wherever possible) is central to understanding the nature and extent of the problem of racial disparities and identifying the necessary action to address this.

18. The Angiolini Review made a number of significant findings and recommendations regarding race and the investigative process, which Home Office should revisit due to their central relevance to the issues in the present Review.[25] It ultimately concluded that "*Where there is evidence of racist or discriminatory treatment or other criminality or misconduct, police officers must be held to account through the legal system. Failure to do so undermines community confidence in the police and is damaging to police and community relations. Community confidence and trust in the police has been undermined in the BAME community and can only be rebuilt with a real effort to learn from institutional mistakes*."

19. It accordingly recommended that "*IPCC [now IOPC] investigators should consider if discriminatory attitudes have played a part in restraint-related deaths in all cases where restraint, ethnicity and mental health play a part (in line with the IPCC discrimination guidelines)*…" and that it "… *should address discrimination issues robustly within misconduct recommendations, including where discrimination is not overt but can be inferred from the evidence in that specific case or from similar cases involving the same*

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[20] Baroness Casey of Blackstock DBE CB, 'Final Report: An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service', March 2023, pp.17, available here.
[21] Home Office, 'Police use of force statistics, England and Wales: April 2021 to March 2022', 15 December 2022, available here.
[22] DHSC, Home Office, MoJ, 'Deaths in police custody: progress update 2021', July 2021, para. 1.20, available here.
[23] Dame Elish Angiolini DBE KC, 'The Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, pp.15, available here.
[24] 'INQUEST, ''I can't breathe': Race, death and British Policing', February 2023, available here.
[25] Dame Elish Angiolini DBE KC, 'The Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, paras. 5.10-5.42 and pp.93, available here.

officer." There remains concern that the IOPC has yet to consistently or effectively adopt this approach in practice.[26]

20. In the IAPDC's view, weakening of the relevant mechanisms of accountability for police officers would be a step in the opposite direction to that recommended by the Angiolini Review and would risk undermining the necessary concerted action and safeguards to avert racial disparity in deaths in custody.

Investigations and learning

21. The IAPDC recently published a report on maximising the effect of the Prevention of Future Death Report process. Several findings and recommendations are relevant to effective post-death investigation and learning processes.[27] In line with our recommendations (based on evidence from coroners, institutional stakeholders and bereaved families), police forces and police officer witnesses must ensure that they approach investigations into deaths in custody openly, non-defensively and with candour, and ensure that the public interest in preventing future deaths is always prioritised over reputational considerations.

22. The Police (Conduct) Regulations 2020 amendment to the Standards of Professional Behaviour – clarifying that police officers have a duty of cooperation with all investigations – is a step in the right direction.[28] But this must be backed by an institutional culture that is committed to learning, upholding high standards, and candour about things that have gone wrong. Post-incident processes must ensure that bereaved families are given essential information regarding their rights and next steps in the process at an early stage. Such family involvement also serves to enhance the quality of post-death investigative processes. Consideration should be given to integrating the views and perspectives of bereaved families into police forces' processes for learning from a death.[29]

23. Timeliness is important to both affected police officers and bereaved family members alike. It is also clearly in the public interest that necessary lessons are identified as soon as possible. But this must not come at the expense of the rigour of the investigation. Proposals to improve the timeliness of investigations should therefore be very careful not to restrict the ability of the IOPC to conduct full and thorough investigations, including in order to ensure full compliance with the State's Article 2 investigative duties. The IOPC must be sufficiently resourced and have the full institutional backing of the Home Office and local police forces to help it complete thorough and fearless independent investigations as expeditiously as possible which command the confidence of all.

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[26] See 'INQUEST, ''I can't breathe': Race, death and British Policing', February 2023, pp.111-112 available here.
[27] IAPDC, '"More than a paper exercise" – Enhancing the impact of Prevention of Future Death Reports', 16 October 2023, available here.
[28] See Home Office, 'Explanatory Memorandum to The Police (Conduct) Regulations 2020 No.4', February 2020, para 7.4, available here.
[29] IAPDC, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', December 2022, para. 15., available here.