ipcc
independent
police complaints
commission

Review of the IPCC's work in investigating deaths

FINAL REPORT
March 2014

Contents

Foreword

One of our most important functions at the Independent Police Complaints Commission (IPCC) is the investigation of deaths following contact with the police. It is important, for the families of those who have died, that they know and understand what happened and why. It is equally important, for the police themselves and for public confidence in policing, that these events are seen to be fully and independently investigated, that there is proper accountability for actions or failures to act, and that lessons are learnt.

For that reason, we decided to conduct a thorough review of our work in this area. This followed criticism and concerns about the approach, timeliness and thoroughness of some of our investigations, particularly those into deaths following the use of restraint or force. We recognised that we would need to make changes to respond to those criticisms and take steps to ensure consistency and quality.

I am very grateful to all those who have given time to this review or responded to the consultation, and for the helpful advice and assistance of the external reference group. I am especially grateful to bereaved families, for whom this has often meant a painful re-living of the worst time in their lives.

In September 2013, we published a progress report, setting out how we were responding, or planning to respond, to the three major themes emerging from our discussions and consultation: independence, effectiveness and engagement. All three raised fundamental questions about the way we carry out these investigations, which were prompting changes in the way we work, or were planning to work. Similar themes had emerged from Dr Silvia Casale's review of the investigation into the death of Sean Rigg; and also from the frustrations and concerns voiced by our own staff during internal discussions.

This final report draws on all that work, and sets out a plan of action. Most of the report describes the process of an investigation, and what we are already doing, or planning to do, to change the way we work. But the changes we are making are not just about process and guidance, staff recruitment and training or the role of the commissioner – important though they are. They need to be rooted in a culture of independence and quality assurance, recognising that those directly affected are at the heart of what we do. In particular, they need to recognise and respond to the concerns and legitimate interests of the families of those who have died. We are in a process of growth and transition, as we prepare to take on more serious and sensitive cases, and these are the qualities that we are committed to building into our work and new structures.

This review has provided us with valuable insights into all of our work, and shows the importance of engaging with and responding to external stakeholders, learning from good practice and seeking to ensure quality and consistency.

We know that the impact of our work can be powerful. It has contributed to better guidance on safer detention, and deaths in police custody have more than halved since the IPCC came into being in 2004. Similarly, our investigations into road traffic fatalities involving the police have led to a statutory code of practice on the management of police pursuits. We have shown that we can produce investigation reports that are thorough and convincing, with findings that are accepted at inquests and subsequent criminal proceedings. But we know that we have not always achieved this, and when we do not this is a significant failing, for families and the public.

"These are the people who can get to the truth. We depend on these people."

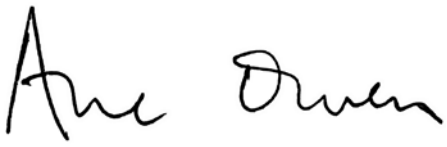
Family member

We do not underestimate the challenges. Every death is an individual tragedy, and some are indicative of wider systemic failings or concerns, for example the approach and support for those with mental illness, or deaths that follow the use of restraint. Deaths during or following police contact have the potential to impact on trust and confidence in the police more broadly. This is particularly true in black and minority ethnic (BME) communities, where a number of high profile deaths have caused particular concern. Those who have lost relatives or close friends have little reason to trust either us or the system, particularly in communities where such trust is already low. We can only earn that trust by engaging with them, and enabling them to participate effectively in the investigation process. Crucially, we need to show that we have been robust in seeking answers to the questions they need answered, that lessons have been learnt to prevent further deaths and, where necessary, that those responsible are held to account. This is also to the benefit of the police themselves – it is clear that, if people do not trust our independence and effectiveness, they will not trust the police service either. Police respondents rightly want to be sure that our work is done to a high quality and is objective; but they too have a responsibility to cooperate fully with our investigations and our search for the truth of what happened. This is an essential part of the democratic accountability of the police. That is why our work in investigating deaths is a key part of meeting the UK's obligations under human rights law.

Our focus is, rightly, on the police. But we know that many of those whose tragic deaths we investigate have been poorly served by other services, in particular in relation to mental health problems. In 2012/13, almost half of those who died in custody and nearly two thirds of those who apparently committed suicide within two days of release from custody are known to have had mental health problems. Clearly, the police must have the right training and approach to deal properly with those who have mental health problems; but they also need to be able to rely on effective and available mental health support. In our new model of working, we will draw upon mental health and other relevant expertise to provide a fuller picture of what has gone wrong and what needs to change.

The findings of this review, and of Dr Casale's review, have already provided a springboard for discussion and action within the IPCC, and staff have responded positively and proactively to the challenges they pose. This review comes at a very timely point in the history of the IPCC. We are in a process of major transition, which will demand a change in the way we operate and are structured. This review has helped to guide the changes we have already made and those that we are planning, and is a model for the way that we want to continue to engage with those who are affected by our work, and to draw on the outside expertise we need.

I know, however, that we will be judged, not by the quality or content of any report that we produce, but by the quality and content of the work we do, and the actions we take as a result.



Dame Anne Owers
Chair

Executive summary

In 2012 the IPCC began a review into the way that we investigate deaths following police contact, with the aim of identifying and implementing changes to ensure that our work in this key area is:

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

We have consulted widely with those affected – in particular those who have been critical of our approach to this important work or of the outcomes of our investigations. We published a progress report in September 2013, detailing the issues and concerns raised, and our response to them. This final report summarises all that we were told, our responses, and most importantly the actions we have taken or are planning to take.

The report begins by addressing the IPCC's independence. It goes on to examine the way we decide what and how to investigate, and then looks at the different stages of an investigation. It considers our engagement with families during an investigation and with police officers and others with an interest. Finally, it discusses the outcome of investigations. The report should be read in the context of the review carried out by Dr Silvia Casale into the investigation of the death of Sean Rigg; and the major transition programme now under way to change the way the IPCC operates and is structured and to increase the resources it has to carry out its work. Both reviews will help guide those changes.

IPCC independence

Independence is a core value for the IPCC and must be expressed and visible in the work we do and in the approach of all our staff and commissioners. However, it is clear from the responses to this review, that our investigations have not always been seen as sufficiently independent of the police service or police culture, or have appeared to treat police more favourably.

Much of the criticism has focused on the number and proportion of ex-police officers and staff we employ. We are committed to increasing the diversity of our staff and taking a multi-disciplinary approach to our investigations. We have implemented a trainee investigator scheme to develop investigators from a range of backgrounds. There is now a more diverse range of previous experience among senior staff in our investigations directorate. Our plans for change include creating a single operational directorate and we will be carrying out a major recruitment campaign, which provides an opportunity to expand the diversity and expertise of our staff. However, we also believe that our investigations benefit from the specific skills and expertise of those who have served in the police. We will ensure that obvious conflicts of interest are addressed, including restrictions on investigators leading an investigation into a force they have previously worked for.

The crucial issue is the culture in which all our staff operate, whatever their previous background. We will ensure that effective systems of management, appraisal and training that support a culture of independence, and that model our values, are built in to the new expanded IPCC.

Scope and remit

Concerns were raised that our remit and the scope of our investigations into deaths are too narrow. We are clear that investigations that engage Article 2 of the European Convention on Human Rights (ECHR) should be inquisitorial and broad in scope, establishing what happened and why, who (if anyone) is responsible, and how a death could be prevented in the future. We will consider any relevant interaction between the police and other agencies in our investigations into deaths. If the actions of other organisations are relevant, but beyond our own remit, we will inform the coroner and other agencies or oversight bodies where appropriate.

Once the Anti-Social Behaviour, Crime and Policing Bill, currently before Parliament, becomes law we will have additional powers enabling us to investigate complaints and conduct matters in relation to private sector contractors carrying out policing functions.

Initial steps in assessment and investigation

Where there is a death or serious injury following contact with the police, the police force must immediately refer the incident to the IPCC. We have reminded chief constables of their duty to refer deaths immediately and will address any delays in our investigation and report.

We were told throughout the review that we need to be clearer about the decisions we make on how and whether such deaths should be investigated and that we need to make these decisions quickly to prevent any delay in taking independent control.

We have set up a dedicated team to deal with referrals to address concerns about consistency and timeliness of decision making. Our new operating model will have a dedicated assessment function. To aid transparency, we will also publish the criteria that we consider when we make a decision about how a case should be investigated. This will include consideration of possible discrimination.

We will initially investigate independently all deaths in police custody and any death following police contact where Article 2 is engaged. This is reviewed during the investigation.

Concerns were raised by many stakeholders about our role in managing the scene of a death or serious injury immediately after the incident – including the time taken for the IPCC to get to the scene, how we then take control and how initial accounts are obtained from officers involved. One of the most contentious issues during the review was the current post incident management (PIM) process, which allows officers to remain together while they prepare their first accounts of an incident. This practice was heavily criticised by voluntary and community groups and serious concerns were also raised by IPCC staff and commissioners.

We are clear that best evidence is obtained if police personnel provide individual accounts of an incident immediately after it happens, and before communicating with each other. We have therefore issued draft statutory guidance for consultation to reflect this. The draft guidance sets out our expectations of the actions the police should take in relation to identifying and securing relevant evidence and ensuring that officers are separated and do not confer before they provide initial accounts.

We welcome the use of technology, such as body cameras and filming of scenes, to ensure accurate evidence. With the growth of the IPCC, we will be able to strengthen our capability to manage scenes independently and effectively. We will have more investigators in more locations. We are already providing direction to local forces and further training and guidance to investigations staff on scene management. We will explore how best to access specialised scene of crime expertise as we grow.

Conducting the investigation

There were concerns from many of those who took part in the review that we do not have the powers and resources we need, but also criticisms about the way we use those that we have. We were told that our investigations take too long and that the quality of investigations is variable, with concerns raised about thoroughness, lack of robust analysis of evidence and sufficient challenge of police accounts. In many cases, these concerns about consistency and quality have also been raised internally by staff and commissioners.

We are already changing the way that we work. We have recently introduced ten quality principles that apply to our investigations and reflect our commitment to ensuring consistent quality in our work. We will also be developing external review as a routine part of quality assurance.

Staff have received additional training in areas such as the use of our powers – including the threshold for criminality or misconduct interviews – and in carrying out probing interviews. We now transcribe significant witness interviews, and are revising our operations manual to reflect the actions outlined in this report. We have improved the oversight of investigations by reinforcing the role of the commissioner and will be developing the standard use of investigation plans to help case supervision, commissioner oversight and reviews. As part of the changes we are making to the IPCC, we are developing a new operational model, drawing on this review and that of Dr Casale, and we will publish our operations manual under the new model.

We welcome the recent change in the law requiring officers to attend witness interviews. Like many of those who contributed to the review, we expect police officers and staff, as public servants, to cooperate fully with our investigations and our search for the truth. We have asked for this to be inserted into the proposed code of ethics for police personnel. We are monitoring officers' cooperation and will refer to this in reports. If we believe that our investigations are still being unduly hindered or undermined by lack of cooperation we will consider seeking further legislative changes.

As the IPCC expands, we will draw on a wider range of specialists, both internal and external. This will include knowledge and experience of mental health related issues, incorporating service user experience. Particular concerns were raised during the review about the rigour of our approach in investigating possible discriminatory behaviour. We will ensure that our decisions about whether we investigate and the terms of reference for our investigations actively consider discrimination issues. We are providing ongoing training for investigators on dealing with allegations of discrimination and will revise our guidance to police in this area.

Engagement during investigations

We accept that we need to improve how we work with families as a matter of priority. Article 2 requires the effective engagement of the family in any investigation into a death. This has not consistently happened. Some of the strongest criticism during the review was about the way we have engaged with bereaved families. This included a lack of sensitivity in our approach, and failure to properly involve families in investigations or to provide sufficient information about what to expect and the progress of the investigation.

We know that when we have been able to develop and sustain good family relationships, this has helped to build trust in the investigation. We recognise that we need to be responsive to families' needs and to understand the effects of bereavement, usually in highly traumatic circumstances. All investigators and commissioners will receive training on bereavement awareness and the stages of grief, and performance reviews will include an assessment of investigators' work with families. With external help and using the findings of this review, we will develop a new model of family liaison as part of our change process, and will explore ways of ensuring regular feedback from families.

We have reviewed the information we provide to families, and will ensure they can meet with the commissioner and lead investigator for their investigation at the start and throughout the investigation. Families will be actively involved in developing the terms of reference for the investigation, to include the questions they would like to be answered. We will share investigation plans, and use them to provide meaningful updates. We are exploring whether and when families could see draft investigation reports. We will ensure that families are given as much information as is possible, and will explain when we cannot provide information, for example because it could harm future proceedings. Wherever possible, press releases will be agreed with families or their representatives, to ensure they are accurate.

As we strengthen our focus on families and complainants, we must also make sure that we communicate appropriately with police officers and staff involved in our investigations and their forces. Police officers and staff reported that the quality of information provided to them was variable, and communication throughout the investigation was often poor. This, and the length of time investigations can take, had a significant emotional impact on them and their families.

We will ensure that, as far as possible without compromising the integrity of the investigation, police officers and staff are kept informed about progress and likely timescale and any delays are explained. Our new operational model and investigation plans will seek to ensure both timeliness and quality. We will share advance copies of press releases with forces, wherever possible, to ensure factual accuracy. We will also consider how best to gather and learn from feedback from officers and staff involved in our investigations.

We have introduced a new critical incident management process, recognising the importance of community confidence and trust. We are consulting on a new oversight and confidence strategy, which includes engagement with communities where there is a particular lack of trust.

We have clarified our approach to press releases, and are making more use of social media to communicate directly with the public in dynamic and fast-moving cases. As part of our change programme, we are reviewing all our communications strategy, to help us be proactive and responsive in our approach to engaging with the media.

Reports, outcomes and learning

Concerns were raised about the quality and accessibility of our investigation reports.

We are implementing a new report writing framework and guidance, to focus investigation reports on the key themes emerging from the investigation, and the questions raised in the terms of reference. All investigators will receive guidance and training in using the new framework. As part of the changes we are making to our structures and ways of working, we will create an enhanced editorial function and will consider alternative accessible formats.

It is important that our investigations make a difference: that they improve policing practice and to prevent future deaths. We must also be able to show that, where necessary, the police have been properly held to account.

We will publish the outcomes of our investigations, and any subsequent proceedings, so that the public are aware of the results of our work. We will also continue to work closely with the Crown Prosecution Service (CPS), and with coroners.

Respondents felt let down when the outcomes of police disciplinary processes did not appear to match the IPCC investigation. Some suggested that the IPCC should have a greater role in the disciplinary process. We do not consider that the IPCC, as the investigating body, should also be the decision-maker on disciplinary outcomes. However, we believe that there is an urgent need to introduce independence and transparency into the police disciplinary system. We have expressed this view in our published response to the recent Home Office consultation and we will continue to make the case for reform.

We received positive feedback for our Learning the Lessons bulletins and thematic reports as means of disseminating learning and sharing good practice. We are currently consulting on a new oversight and confidence strategy, which sets out how we will build on this area of work and identify emerging themes. We are also strengthening our liaison with other bodies, so that our findings feed into the standards set by the College of Policing and the inspections carried out by Her Majesty's Inspectorate of Constabulary (HMIC).

A number of stakeholders felt that more needs to be done to ensure sustained learning across the police following our investigations. A widespread view was that there should be a requirement for forces to respond formally to our recommendations. This will be a statutory requirement, when the Anti-Social Behaviour, Crime and Policing Bill becomes law. If insufficient action is taken we will report this to police and crime commissioners and publicise it further. We are developing systems and training staff to ensure that our recommendations are informed by knowledge of best practice as well as previous recommendations made by us or others.

A plan of all the actions being taken is included at Annex C.

1 Introduction

Investigating deaths following police contact is one of the most important tasks undertaken by the IPCC. We do not investigate all such deaths independently, but where they may be the result of police action, or failure to act, we must do so. Since 2012, we have been reviewing the way we do this work, consulting widely with those affected, in particular those who have been critical of our approach or the outcomes of investigations.

In September 2013, we issued a detailed progress report, setting out the main areas of concern – independence, effectiveness and engagement with families and others – and the steps we had already taken or were planning to take to deal with those concerns. We then hosted a consultation event with those who had responded to our review, to discuss some of these issues directly.

This report summarises all that we were told, our response and, most importantly, our actions and planned actions. It should be read in conjunction with the progress report[1] and also the independent external review of the IPCC investigation of the death of Sean Rigg[2] carried out by Dr Silvia Casale, and the action plan[3] and progress report on her recommendations.

Article 2

Article 2 of the European Convention on Human Rights (ECHR) places an obligation on the state not to take life, except in very limited and defined circumstances, and to take reasonable steps to protect life where there is a real and immediate risk. If there is an indication that a death may be the result of police action, or failure to act, Article 2 requires that there is an independent and effective investigation to determine the circumstances and causes of the death.[4] Our work is an important part of the way the state meets that obligation, alongside the work of coroners and the Crown Prosecution Service (CPS). The obligations arising from Article 2 shape the way that we investigate deaths involving the police. As well as determining how and why a person died, and whether any individuals are at fault, our investigations should seek to ensure that similar deaths can be prevented, and should effectively engage bereaved families in the investigative process.

1. Visit the IPCC website for details: www.ipcc.gov.uk/page/review-ipccs-work-relation-cases-involving-death
2. Visit the IPCC website for details: www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/Review_Report_Sean_Rigg.PDF
3. Visit the IPCC website for details: www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/action_plan_in_response_to_review_of_Sean_Rigg.pdf
4. Annex A provides a further outline of our approach to Article 2 of the ECHR.

Therefore, when we conduct an investigation into a death, we have a responsibility to the families of those who have died to ensure that it is both effective and independent. It is also important that the wider public has confidence in our work. Finally, and importantly, we must help the police learn the right lessons from these tragic incidents. As such these cases inevitably, and quite rightly, attract a great deal of attention, our handling of them shapes public perceptions of the police complaints process and of our own role in holding the police to account. So we need to demonstrate that our investigations are effective and thorough, fully independent of police and other interests, and that we proactively and sensitively engage with the families of those who have died.

The review of our work in investigating deaths

In the course of the review, we have engaged with a wide range of individuals and groups who have a stake in our work in cases involving a death. The review was structured around the following themes:

- how we work with bereaved families
- decisions about our level of involvement in an investigation (or the 'mode of investigation')
- how we conduct our independent investigations
- how we work with other organisations, including the police, CPS and coroners
- our engagement with the public, communities and other interested parties
- how we can demonstrate our independence and build public confidence

We used a variety of methods to engage with stakeholders.

- We published a consultation document[5] in October 2012.
- We asked INQUEST (a charity that supports and advises bereaved families) to host two listening days with bereaved families.
- We held a number of meetings, workshops and events with other stakeholders, and with our own staff.
- We commissioned NatCen Social Research to carry out independent research into the views and experiences of bereaved families, IPCC staff and commissioners, police officers and others – so that people who might not be willing to provide views directly to the IPCC could feed into the review through an independent organisation. The NatCen research has informed the findings of the review, and their report[6] is published alongside this report.

5. View our consultation document online: http://www.ipcc.gov.uk/page/review-ipccs-work-relation-cases-involving-death
6. View the NatCen research report online: www.ipcc.gov.uk/page/review-ipccs-work-relation-cases-involving-death

Full details of our consultation activities are included at Annex B. We have published the submissions received and the notes from our consultation activities alongside this report.[7]

In September 2013 we published a progress report[8] to share emerging findings from the review and explain some of the actions we were already putting in place. In October 2013 we invited a range of individuals and organisations who had taken part in the consultation to an event, which provided an opportunity to get further feedback on the actions we had taken and some of those we were considering.

A committee, including three commissioners, chaired by Dame Anne Owers, has overseen this work on behalf of the Commission. We also set up a small external reference group to provide independent advice. The members of the reference group were:

- Deborah Coles, Co-director of INQUEST
- Matthew Ryder QC
- Lord Dholakia, member of the House of Lords

Mike Hough, co-director of the Institute for Criminal Policy Research (ICPR), was a member of the reference group through the consultation phase of the review, but withdrew from this role in June 2013 to assist with the drafting of the progress report and this final report.

Changes to the IPCC

Since this review began, the context for the IPCC's work has changed significantly. Last February, the Home Secretary announced her intention to transfer resources from police forces to the IPCC so that we can independently investigate all serious and sensitive cases. That transfer of resources will take place gradually over the next three years. In its initial phase, 2014/15, the focus will be on securing the infrastructure we need to increase our work – premises, staff, a new organisational and operational design, and training. By the end of that year, we will be able to take on more independent investigations, and gradually increase that number over the next two years.

7. Consultation submissions and notes are available online: www.ipcc.gov.uk/page/review-ipccs-work-relation-cases-involving-death
8. View the progress report online: http://www.ipcc.gov.uk/sites/default/files/Review%20of%20the%20IPCCs%20work%20in%20investigating%20deaths%20-%20Progress%20report.pdf

This will have two important implications for our work in investigating deaths. First, it will mean that we will be able to investigate more deaths and near-deaths ourselves. Currently, we investigate independently all deaths where there may have been a breach of Article 2 by the police and, at least initially, all deaths in custody. More resources will enable us to investigate independently a wider range of cases, including, for example, more so-called 'near misses', where someone nearly dies in circumstances where it is important to learn lessons for the future.

Second, a much larger organisation will be better able to support all our work, including the investigation of deaths. It will include, for example, a separate assessment function, to act as a triage point for all incoming work, making decisions on the cases to be investigated, and the appropriate allocation and resourcing. We will also create a single operational function, covering investigations and casework, to support the wide range of investigations we will be carrying out.

In addition, we will have more offices, extending our national footprint. An increased number of staff will give us much more flexibility in how and who we deploy, and will allow us to recruit people from a variety of disciplines, including experts in areas of key concern to this review, such as mental health, discrimination, scene management and forensics.

Our plans for growth and the effect we expect this to have on deaths investigations are referred to throughout this report.

Structure of the report

The report begins by addressing the IPCC's independence, a key issue for the review. It then goes on to consider evidence in relation to the scope of our investigations into a death. The next two chapters go through the different stages of an investigation. Chapter six looks in detail at our engagement with families throughout the investigation as well as our engagement with police officers and others with an interest in our work in these cases. The final chapter considers what happens at the end of an investigation including how we can work to help prevent further deaths in the future. Each chapter considers the feedback received during the review and our response to it, and the principles and actions that will determine what we do and how we do it.

Throughout the report, the feedback received has been categorised according to five respondent groups: families, voluntary and community groups, statutory organisations, police, and IPCC staff and commissioners.[9] Full details of our consultation activities and an outline of how we have classified respondents into these groups are included at Annex B.

Acknowledgments

We would like to thank the members of the reference group who assisted us during the review:

- Deborah Coles (INQUEST)
- Lord Dholakia
- Mike Hough (ICPR)
- Matthew Ryder QC

We also thank those who shared their views with us as part of the consultation.

Thanks also go to staff at the Institute for Criminal Policy Research Birkbeck College, University of London (ICPR), and NatCen Social Research (NatCen) for assisting in the review and helping to write this report:

- Tiggey May (ICPR)
- Jessica Jacobson (ICPR)
- Caroline Turley (NatCen)
- Ashley Brown (NatCen)

9. An outline of how we have classified respondents into these groups is included at Annex B.

2 IPCC independence

Most of this report sets out the processes and practices that we are committed to implementing, and the principles that lie behind them. These are essential foundations for the consistent and thorough approach that all participants to this review have asked for, and which bereaved families in particular need and deserve.

However, procedures by themselves are not enough. They need to be carried out within the right culture and with the right values, in a way that clearly demonstrates our independence from police, government and any other outside pressure. This is a fundamental requirement of an Article 2 investigation into a death. It is crucial to public confidence in us and our investigations. It is also important for the police service itself that we are seen to be independent and that there is trust in our findings, whether or not they find any fault or wrong-doing.

Independence is crucial to our mission and purpose. It is reflected in our statutory framework – for example, we alone decide what we will investigate, and how. All of our work, and in particular our independent investigations, are overseen by commissioners who can never have worked in the police service. Throughout this report, we make reference to the newly issued guidance[10] on the proactive role commissioners should take in investigations.

This is important – but the responsibility for independence of action and thought cannot rest solely with commissioners. It must be reflected in the structure and culture of the whole organisation and expressed and visible in the work and approach of all our staff. It is clear, from the responses to this review, that this has not always been the case: where our investigations have not appeared sufficiently independent of the police service or police culture or where we have been perceived to treat police more favourably.

Much of the criticism has focused on the number and proportion of ex-police officers and staff we employ. Currently, 25 per cent[11] of our staff have worked in the police service (around 14.7 per cent as police officers), and this rises to 40 per cent (28 per cent as police officers) in the investigations directorate.[12]

"[A] key area of concern about IPCC's actual or perceived ability to conduct independent investigations is the high number of their investigators who are ex-police officers or ex-civilian police staff. However robust IPCC systems and policies to prevent favourable bias are, there will be a problem of perception when former police officers investigate the police."

Equality and Human Rights Commission

10. View the guidance on the IPCC website: http://www.ipcc.gov.uk/Documents/investigation_commissioner_reports/Commissioner_Role_in_Independent_Investigations.PDF
11. Staff breakdown correct as at 22 January 2014 (total 538). This includes all staff employed at the IPCC (excluding temps and Commissioners) and includes staff employed on the Hillsborough investigation.
12. Correct as at 22 January 2014.

We are committed to increasing the diversity of our staff, including those involved in investigations. During the course of the review, we have already taken a number of steps towards this:

- **a trainee investigator scheme**, which has resulted in the recruitment of 44 trainees, 13 of whom are now fully trained investigators. None of the trainees has previously worked as a police officer or member of police staff.
- **a more diverse range of backgrounds among senior staff in the investigations directorate**:[13] five out of 11 senior investigators, and 10 out of 19 deputy senior investigators have no police background
- **developing a multi-disciplinary approach to investigations**, involving not only the commissioner, but also legal and communications colleagues

As we increase the size of our workforce, we will be able to add to the diversity of staff undertaking investigations:

- **joining together casework and investigations** to create a single operations function will result in a more varied mix of experience and backgrounds among those conducting investigations
- we will need to recruit a large number of new staff to carry out investigations, and **our brief to recruitment agencies highlights the importance of obtaining a workforce that is more diverse, in relation to background and all other aspects of diversity**. We will seek to **recruit people with specific expertise acquired outside policing**, such as mental health, discrimination and forensic science experts
- we have begun to **recruit associate commissioners**,[14] **to assist with oversight of investigations**, who, like commissioners themselves, can never have worked for the police

However, like many of those who responded to the review, we recognise that we need to draw on the specific skills and expertise of those who have served in the police and have experience of carrying out criminal investigations. The management of scenes of crime, the analysis of police intelligence and use of databases are areas that require specific expertise and that, if handled wrongly, can undermine the effectiveness of an investigation. Other investigatory bodies, such as the Care Quality Commission, are rightly criticised if they lack the relevant professional expertise.

13. Correct as at 22 January 2014.

14. Associate commissioners are members of IPCC staff. They support commissioners in their responsibility for oversight of certain cases and forces but have no governance responsibilities. In overseeing cases and forces they will act as commissioners, providing independent scrutiny and oversight.

We can and will take steps to ensure that any obvious conflicts of interest are identified and dealt with. This already happens in relation to individual cases and staff members, but **we plan to extend this, as we expand, to ensure that there are specific restrictions on investigators leading an investigation into a force where they have previously worked**. **We are also revising our conflict of interest policy for all staff and commissioners, and are strengthening the initial training on conflicts of interest that is provided to all new staff.**

However, the crucial issue is the culture within which all our staff operate, whatever their previous background. **We are already planning to expand our training programme for all staff, to include training on identifying and challenging personal bias**. **We are also updating our corporate induction programme and will use the findings of this review to reinforce the messages we deliver about the IPCC's purpose, values and history**. As already stated, in the new IPCC there will be a single operations function, headed by a chief operating officer (COO). Joining investigations and casework staff will involve cultural as well as operational change. One of the COO's key tasks will be to build on the progress identified in this report and to ensure that effective systems of management, appraisal and training, support and model all our values and a culture of independence. This will involve significant changes of approach and working methods.

Our independence will be judged by the outcomes of our investigations: the extent to which they are, and are perceived to be, robust, thorough and effective – and that is why implementing the changes set out in the following chapters is crucial.

3 Scope and remit

This chapter considers whether the IPCC's investigations into deaths are broad enough to answer the key questions about why a person died. It looks at evidence received and our response in relation to the following:

- scope of Article 2 investigations
- IPCC powers to investigate contractors and other third parties

The parameters and scope of each individual investigation are set in its terms of reference, which are discussed later in this report.

Background

The purpose of an Article 2 investigation is to establish how and why a person died, whether any individuals are at fault, and to identify any learning to help ensure that similar deaths can be prevented in the future.[15]

Investigating a death following police contact may raise questions about the actions (or inactions) of other organisations such as health and social care providers, emergency services or prison services. In some cases a parallel investigation may be carried out by another statutory body looking at the actions of the other organisation(s) involved.

Police forces are also increasingly outsourcing some of their functions (particularly in relation to staffing custody suites) to non-police private providers. We currently only have limited powers over staff employed by private contractors. Only people who have been specifically designated as a detention or escort officer by the chief constable of the force they work for fall directly within our remit.

Our response to the evidence from the review

Concerns were raised that our remit and the scope of our investigations into deaths are too narrow, as agencies other than the police may be involved in the circumstances surrounding the death.

Our response to these concerns is outlined on the next page.

15. An overview of our approach to Article 2 investigations is provided at Annex A.

IPCC response at a glance

Scope of independent investigations into deaths

Principle:

➜ Article 2 investigations should be inquisitorial and broad in scope, establishing what happened and why, who (if anyone) is responsible and how a death could be prevented in the future.

Actions:

- We will consider any relevant interaction between the police and other agencies in our investigations into deaths. If the actions of other organisations are relevant, but beyond our own remit, we will inform the coroner and other agencies or oversight bodies where appropriate.
- We will develop both internal and external expertise in areas that relate to our work, like healthcare (see the *Conducting investigations* chapter).
- We have asked for additional powers in relation to private sector contractors carrying out policing functions, to ensure that we are able to investigate complaints and conduct matters associated with them. These powers are included in the Anti-Social Behaviour, Crime and Policing Bill, which is currently before Parliament.

Discussion of the evidence and our response

Scope of Article 2 investigations

Many stakeholders – mainly from the voluntary, community and statutory sectors, but also from the police and IPCC staff – voiced concerns that the scope of our independent investigations is too narrow. It was suggested that this should be extended to cover other agencies that may have been directly involved with the person who has died before his or her death. These agencies would include, most notably, health (including mental health) services, especially if the person had recently been in receipt of treatment. The narrow scope of our investigations into deaths was said to frustrate families, skew investigations towards police officers and staff, hamper the learning of lessons, and negatively affect public perceptions of the police.

"The role of the IPCC would... be more effective if they had wider reaching powers to deal with external bodies associated with complaints they deal with."

West Midlands Police

Dr Casale's independent review of our investigation into the death of Sean Rigg raised similar concerns about the scope of the investigation.

"The review recommends that, in relation to future deaths in police custody, the IPCC looks not only at police involvement in the circumstances surrounding the death, but also more widely at other issues, including the contribution of other agencies to the circumstances surrounding the death before contact with the police."

Rigg Review

By contrast, some stakeholders urged caution in relation to any extension of our investigative remit beyond the police. Some IPCC staff said that problems arise when the scope of an investigation is too broad, as this means that the work lacks focus, can become unwieldy, and cannot be completed within an appropriate timeframe.

We are clear that **Article 2 investigations should be thorough and wide-ranging, establishing what happened and why, and drawing conclusions beyond misconduct and criminal behaviour such as systemic problems or poor practice**. We recognise that when a death occurs during or following contact with the police, in many cases the actions of organisations other than the police may also need to be considered to answer all relevant questions and concerns.

The focus of an IPCC investigation will always be the actions of the police and we will not always be best placed to consider the actions of non-police agencies.

However, **we will ensure that any relevant interaction between the police and other agencies is considered**. We are already taking this approach. In a recent investigation into a death in custody[16] our terms of reference include consideration of the involvement of paramedics as well as relevant joint working protocols, policies and procedures between the police force and the ambulance service in relation to detention under section 136 of the Mental Health Act.

16. For more details of this case see: www.ipcc.gov.uk/news/ipcc-outlines-scope-investigation-death-leon-briggs

If the actions of other organisations are relevant to the investigation, but are beyond our remit, we will highlight issues to the coroner and to other agencies or oversight bodies where appropriate. We will also work with other organisations conducting parallel investigations or enquiries, such as the Health and Safety Executive and authorities undertaking serious case reviews or domestic homicide reviews.

Private contractors

A wide range of stakeholders, including statutory and police respondents, expressed the view that we should have powers to investigate contractors to the police service, including prisoner escort contractors, health providers and others.[17]

"The IPCC has limited powers over contracted out staff who are not police officers or members of police staff. This is problematic given that during our police custody inspections we increasingly find that custody is being operated by private contractors and contracted staff are increasingly performing the roles of detention officers and custody assistants. The IPCC's remit should extend to private providers and their staff."

Her Majesty's Inspectorate of Constabulary

We recognise that our limited powers in relation to privately contracted staff undertaking policing functions presents a gap in oversight. This potentially undermines our ability to carry out thorough investigations and risks damaging public confidence. **The IPCC asked for legislative change to expand our remit to cover complaints and conduct matters in relation to private contractors carrying out policing functions.** This is included in the Anti-social Behaviour, Crime and Policing Bill currently before Parliament.

17. The IPCC currently has direct powers to investigate police officers, police staff and designated detention and escort officers.

4 Initial steps in assessment and investigation

This chapter considers the initial actions taken by the IPCC and the police after a death, covering the referral of the incident to the IPCC and our decision about whether and how to investigate and the initial management of the scene and evidence, including witness accounts.

4.1 Referrals and assessment

This section considers the evidence and our response in relation to:

- timely referral by the police
- criteria for mode of investigation (MOI) decision making
- process for MOI decision-making – transparency, timeliness and consistency

Background

Under the Police Reform Act 2002, police forces must refer the following to the IPCC:

- any complaint alleging that police conduct has resulted in a death
- any police conduct matter relating to circumstances where there has been a death
- any death of a person in police custody
- any death where there is an indication that police contact may have caused or contributed to it

The police must refer such cases without delay.

We are then responsible for deciding whether and how a death or serious injury should be investigated. There are four ways a matter can be investigated (modes of investigation) as outlined below.

Modes of investigation (MoI)

Independent:	IPCC investigators conduct the investigation, with an IPCC commissioner having ultimate responsibility for it.
Managed:	Investigation is conducted by the police under IPCC direction and control under the ultimate responsibility of an IPCC commissioner.
Supervised:	Investigation is conducted by the police with oversight by the IPCC, who must approve the investigator and agree the terms of reference and investigation plan.
Local:	Investigation is conducted by the police with no IPCC involvement.

We will always carry out an independent investigation if it appears that Article 2 of the European Convention on Human Rights (ECHR) is engaged (see chapter 3).

Our response to the evidence from the review

Concerns were raised by contributors to the review about the timeliness of referrals made by the police to the IPCC; the criteria we use to decide whether to investigate deaths independently; and the process by which these decisions are made.

In response, we have reviewed and revised some of our practices in relation to referrals, and clarified others.

IPCC response at a glance

Referral and mode of investigation decision-making

Principles:

- Police forces (and other bodies within our remit) must notify us of a death immediately once the force becomes aware of the death or serious injury, unless there are exceptional reasons.
- Any investigation into a death where it appears that Article 2 of the ECHR is engaged, including all deaths in custody, are initially dealt with as an independent investigation. This is reviewed during the investigation.

Actions:

- Chief constables have been reminded of their duty to refer deaths immediately. We will address any delays in referral as part of our investigation and final report. We will consider whether this raises issues of misconduct.
- We have set up a dedicated team to deal with referrals to address concerns about consistency, timeliness and transparency of decision making. We will use the learning and experience from this work to develop a dedicated assessment function as part of our new organisational structure.
- We will publish the criteria that we consider when we make a decision about how a case should be investigated.
- Decisions about whether to investigate independently will include consideration of whether discrimination (for example because of race, mental health, gender, disability or sexual orientation) may be a relevant factor in the death.
- With more resources, we will be able to do more independent investigations, for example where a death has been narrowly avoided.

Discussion of the evidence and our response

Referral by the police of cases involving a death

Some voluntary organisations and community stakeholders, as well as IPCC staff, raised concerns about delays in the referral of cases (and particularly deaths) by the police. It was also suggested that some police forces may lack understanding of the criteria and process for referring cases to the IPCC, and that clearer, enforceable guidance for the police on IPCC referrals is needed.

"There is a need for clear and enforceable guidelines to ensure that forces make referrals as soon as possible (within a specified number of hours) after a death."

Police Action Lawyers Group

Any delay in the police referring a death to the IPCC can result in delays in the deployment of IPCC investigators that undermine the independence and integrity of the investigation from the start. To address this issue, we wrote to all chief constables in August 2013 to clarify their responsibility to notify us of a death as soon as possible, which should be immediately, unless there are exceptional circumstances that prevent this. If there are exceptional circumstances, a referral should still be made as soon as possible, with an explanation and justification. The new referrals team is gathering information about timeliness and we are following this up.

We will actively consider the timing of referral as part of our investigation. If there appears to have been unreasonable delay, this will be included in the terms of reference for the IPCC investigation and will therefore be scrutinised and reported on as part of the investigation. This approach has already been put into practice. We are currently investigating a death where the delay in referral forms part of the investigation and misconduct notices have been served on the officers responsible for referral.

Mode of investigation decision-making

The IPCC's decision-making process on modes of investigation was criticised by a substantial number of stakeholders – particularly police, but also by others including voluntary and community groups, statutory stakeholders and IPCC staff – on grounds of delay, inconsistency and lack of transparency.

Some stakeholders referred to the IPCC taking too long to decide whether to investigate a death independently. Such delays were felt to have serious knock-on effects on the investigative process, on engagement with other agencies, and on family and public confidence.

"There are concerns about the clarity of this decision-making process, but more particularly about the speed at which it is undertaken."

Police Federation

Some stakeholders argued that the way we apply the criteria for decision-making lacks clarity and appears inconsistent, for example how we apply Article 2 considerations. Concerns were raised among IPCC staff and police stakeholders that decisions appear to be influenced by resource considerations or public pressure and that these considerations override the formal decision-making criteria.

"To secure and maintain public confidence, decisions to conduct IPCC investigations should be consistent, fair and based on the nature of the case rather than the level of media coverage the case has received."

Suzy Lamplugh Trust

Our failure to explain fully and publicly how and why decisions are made adds to concerns about the consistency and quality of decision-making.

"It is not clear on occasions why certain decisions have been taken and how the assessment on the engagement of Article 2 is being applied. For example, similar incidents... have been treated differently with no apparent rationale being provided."

Norfolk and Suffolk Police

Some stakeholders (particularly voluntary and community groups) also suggested that we should independently investigate more cases involving a death. It was variously suggested that we should independently investigate – at least initially – all deaths in custody; all deaths and all near-deaths in custody; or all deaths where there may have been police contact.

"All deaths in police custody and following police contact should trigger an independent investigation and as the full evidence emerges, if appropriate, [this] could later be changed to a less resource-intensive investigation. To approach investigations the other way around runs the risk of missing crucial evidence or issues and thus damaging public confidence in the system."

INQUEST

We agree that any death in custody should initially be dealt with as an independent investigation. This is already happening. We also agree that **any other death during or following police contact where it appears that Article 2 of the European Convention on Human Rights (ECHR) is engaged should be independently investigated**.[18] That applies to cases where police action, or failure to act, may have contributed to the death. In some cases, early enquiries may clearly establish that the death had no connection with police actions or failure to act and it may then be appropriate to review the level of IPCC involvement in the investigation.

We have been open about the limitations that our resources have placed on our capacity to investigate some cases independently. We do not believe that this has prevented us from investigating those deaths that engage Article 2. Nevertheless, with expansion, we will be able to investigate more matters independently. The Police Reform Act requires the IPCC to have regard to the seriousness of the case, and the public interest, in deciding whether to investigate independently. To ensure the transparency of our decision making **we will publish the criteria that we use when making such a decision.**[19]

We believe that there is value in having a specialist team in the organisation to make decisions on cases referred to us, including decisions about how deaths following police contact should be investigated. This will help us to monitor and address any issues regarding consistency and timeliness in decision making. It will also allow more specialised training of the staff involved in making these decisions.

In this context, **we have set up a dedicated team to deal with referrals.** The new unit became operational in November 2013. Part of its work is to monitor any delays in referrals and report on and analyse any trends or issues in relation to a particular police force or issue. This feeds into both the terms of reference for individual investigations and our liaison work with forces.

We have provided **additional training to staff in this unit and those on call who will make recommendations and decisions about whether we will investigate**, including training on:

- articles 2 and 3 of the ECHR
- receiving referrals from the police by phone
- effectively communicating the rationale for our decisions

We will use the learning and experience of the referrals unit to develop a dedicated assessment function as part of our new operating model.

18. An outline of our approach to Article 2 and the type of case this applies to is provided at Annex A.

19. Paragraph 15, Schedule 3, Police Reform Act 2002.

Near-deaths

Some respondents suggested that we should routinely investigate what are called 'near-miss' cases in custody (those where a death or serious injury has been narrowly avoided).

"Incidents of death, near death and near misses in police custody suite, should always result in an independent IPCC investigation."

Her Majesty's Inspectorate of Constabulary

These incidents, unless they lead to a serious injury, do not automatically require referral to the IPCC under the current legislation. However, they clearly provide an important opportunity for learning and review of practice to help ensure that similar incidents are prevented in the future. We are not seeking to amend the referral criteria at this time. However, with more resources, we will be able to decide to independently investigate a wider range of cases and this is likely to include more 'near miss' cases. We are also developing our capacity to carry out thematic work, which could include work on 'near miss' incidents, and to identify whether patterns emerge.

Identifying diversity and discrimination issues

A number of stakeholders criticised us for failing properly to probe possible discriminatory behaviour if this could be a relevant factor in a death. Similar criticisms were raised as part of Dr Casale's review of our investigation into the death of Sean Rigg.

"The IPCC should not be afraid to identify the primary, contentious features in a case such as race, mental health and restraint. This is not to prejudge the investigation or with the purpose of ruling those issues in or out but to make clear the IPCC is aware of and has identified the primary concerns and issues that need to be pursued."

INQUEST

To ensure that issues of possible discrimination are factored into our approach to investigating deaths from the beginning, **we have amended our referral assessment process. Decisions about whether to investigate independently must include an assessment of whether the protected characteristics[20] of the person who has died (such as race, mental health, gender, disability or sexual orientation) may be relevant to the death and the investigation**. There will be a similar assessment when we develop the terms of reference for an independent investigation, as described in the *Conducting the investigation* chapter.

20. The 'protected characteristics' are set out in the Equality Act 2010 and discrimination against these characteristics is unlawful. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

4.2 Post-incident management

This section considers evidence received and the IPCC response in relation to:

- deployment of staff following a death
- scene management
- separation of officers, first accounts and conferring

Background

If someone dies during police contact, the police will always be on the scene before the IPCC. The local police force should immediately secure the scene and refer the matter to the IPCC. As soon as that happens, we make a decision about whether to send investigators to the scene straight away.

We cover England and Wales and at present have offices in only four locations. It can therefore take some time (in some cases several hours) for our investigators to reach the scene depending on how far they need to travel. During this time, the local force is responsible for securing the scene (for example, cordoning off the area where the death occurred) under our direction. The police must by law assist us during this process.

In an independent investigation, IPCC investigators take responsibility for direction and control of the scene – for example, deciding the extent of any forensic examination of the scene and what, if any, specialist forensic scientists are required to attend. The actual forensic examination is carried out by police crime scene examiners under our direction. They are either from a neighbouring force or the force where the incident took place.

IPCC investigators ensure that initial accounts are obtained from the police officers and staff and arrange for police witnesses to attend interviews if required. Throughout this time, the police remain under an obligation to ensure the preservation of evidence and the integrity of our investigation, to assist us and to carry out activities as directed.

Our response to the evidence from the review

The actions taken to secure evidence immediately after someone has died are crucially important in finding out what happened. They can also affect the level of confidence that families and the wider public have in the independence, findings and outcome of the investigation. Concerns were raised by many stakeholders about our role in managing the scene of an incident immediately afterwards – including how we take control of the scene, deploy our own staff and obtain initial accounts from officers involved.

The principles behind our approach and the actions we are taking to strengthen our role and clarify our expectations of the police immediately after a death are outlined below.

IPCC response at a glance

Post-incident management

Principles:

- The police have a statutory duty to obtain and preserve evidence, and to cooperate with us in our investigations.
- Our investigators will provide direction and control of scenes of death that are being independently investigated to ensure preservation of the scene and the collection and seizure of time-sensitive evidence.
- Best evidence is obtained if officers provide individual accounts of an incident immediately after it happens, and before communicating with each other to prevent conferring.

Actions:

- We have developed draft statutory guidance under Section 22 of the Police Reform Act in relation to achieving best evidence in death and serious injury investigations. This sets out our expectations of the actions the police should take to identify all potentially relevant evidence and preserve the integrity of that evidence. The draft guidance also specifies that key policing witnesses should be separated before providing their initial accounts and should not confer.
- Investigators have received further training and guidance on scene management to ensure that they have the skills and confidence to take control of a scene, both remotely and on arrival, and to give and record guidance to police and contracted forensic providers.
- Additional resources will allow us to open more offices and increase our geographic coverage. We will also review our on-call system, and consider how best to obtain specialised scene of crime expertise.
- We will explore with the Association of Chief Police Officers (ACPO) the feasibility of filming the process of scene preservation to ensure that evidence is secured and public confidence is maintained.

Discussion of the evidence and our response

Deployment

Police respondents to the review reported different experiences of IPCC deployment of investigators to the scene. Some forces criticised delays, while others were satisfied with the speed of deployment. Concerns about delays in attending scenes were also raised by a number of voluntary and community sector stakeholders as well as by IPCC staff. It was also suggested that the introduction of a national on-call system had made this problem worse.

It was recognised that delays tend to reflect resource constraints, distances to be travelled by investigators, and other logistical issues. However, stakeholders felt that this had a negative impact on the perceived independence and effectiveness of the investigation.

"The national 'on-call' IPCC system inevitably leads to a delay in IPCC attendance at 'golden hour' scenes and this delay can sometimes undermine public confidence."

South Wales Police

We recognise that taking early control of the scene of an incident involving a death or serious injury is an important part of ensuring public confidence in our investigative work. The time immediately after such an incident – when the scene and evidence is initially secured, particularly any time-sensitive evidence, and when key accounts are taken – is vitally important for an effective investigation.

The limited number of our office locations presents significant challenges to timely deployment. In many cases we investigate incidents that have occurred a considerable distance from the nearest IPCC office or location of on-call staff. The gaps in geographical coverage have increased following the closure of our midlands office in 2012 because of budget cuts.

Our increased resources will allow us to open more offices and improve the geographical spread of our offices. Priority will be given to securing suitable offices in the midlands and to the west of London (to ensure better coverage of the south west). In addition, we may need premises that provide better coverage of our work in the north and east of England.

When designing the operating model for an expanded IPCC **we will also review our on-call system**. This includes reviewing the number and location of investigations staff on call and deployment out of hours, as well as scene management capability.

A better spread of offices across England and Wales, additional investigative staff and a revised on-call model will all reduce the delay in IPCC staff attending the scene. However, we will remain reliant on the local police force

to notify us of a death and to secure the scene and preserve evidence initially and it is important to note that even with a larger IPCC some time will still pass before our investigators arrive. The police have a duty to cooperate with us and to ensure the preservation of the scene and evidence.

We have already taken steps to cover the interim period before our investigators arrive. **A senior investigator provides and records direction and guidance to local forces, by telephone, before our own investigators arrive on the scene**. This record is added to the case file. The police force's responsibility during this period will also be covered in the statutory guidance we are developing (see below).

Scene management

Stakeholders from various sectors said that our staff may lack the necessary expertise, training and support to manage crime scenes, and that this can result in failures to seize and preserve evidence adequately and quickly. Lack of expertise was also said to lead to an over-reliance on the local police force to manage the scene. Many stakeholders (voluntary and community groups, police and others) were concerned about the implications of this, including a real or perceived lack of independence in the crucial initial investigative work.

Other related difficulties included confusion over the respective roles of the IPCC and the local force in relation to evidence gathering, and a perceived tendency for our investigators to defer to the local force in decision-making.

"The IPCC has a limited number of investigators to deploy to the scene of an incident. While an IPCC senior investigator will give the force instructions with regard to what action should be being undertaken at the scene, this may not be viewed as sufficiently independent from the viewpoint of maintaining public confidence."

Northamptonshire Police

Stakeholders suggested that we should provide clearer direction to local forces, or should be better resourced to do the work ourselves. Another suggestion was that we should have arrangements to deploy neighbouring or other external police forces for scene management.

IPCC investigators have been provided with further training and operational guidance on scene management to ensure that they have the skills and confidence to take direction of the scene both remotely and on arrival. This will form part of the standard training for investigators. They will make detailed notes of decisions and actions taken at the scene.

We have developed draft statutory guidance under Section 22 of the Police Reform Act on achieving best evidence in death or serious injury matters.

This sets out our expectations of the actions the police should take to identify all potentially relevant evidence, witnesses and scenes and preserve the integrity of that evidence. Issuing Section 22 guidance requires a period of public consultation, during which we will invite views from all those who contributed to the review. It then requires approval from the Secretary of State.

When such guidance is issued, police forces must have regard to it. Any failure to do so will be noted in the investigation report and highlighted to the coroner. It will also be raised with chief officers and police and crime commissioners. Failure to do so will be part of our findings and conclusions in investigations, and could be used in evidence in any disciplinary proceedings.

As the local police force will continue to be involved in the management of the scene, we have considered whether additional independent oversight could be provided by filming the preservation of the scene and evidence. This suggestion was discussed at the consultation event in October 2013 and was supported by a number of people from the community and voluntary sectors. It was also suggested that police officers should wear body cameras during high-risk planned operations (for example, where firearms officers are deployed) to provide additional impartial evidence. **We have supported the proposal for officers to wear body cameras when going out to emergencies and firearms incidents. We welcome the fact that this is now being widely discussed, with a view to implementation, and that some forces are already using this technology**.

We consider that there is value in exploring how technology could be used to film the scene management process. In practice, any such filming would need to be undertaken by the local police force. **We will explore with the Association of Chief Police Officers the possibility of filming the process of scene preservation to ensure that evidence is secured and public confidence is maintained**.

With more resources, we will be able to strengthen our capability to manage scenes independently and effectively. This will include consideration of whether we should recruit our own scene of crime specialists on a permanent or contractual basis, to be deployed to lead the management of scenes, or advise on scene management strategy.

Separating officers and first accounts

One of the most contentious issues during the review was the current post incident management (PIM) process, which allows officers to remain together while they prepare their first accounts of an incident. This was heavily criticised by voluntary and community groups, on the grounds that it allows officers to confer, with the possibility of collusion or at least the unintended cross-contamination of accounts. IPCC staff also expressed concern about the effect on the integrity and independence of the investigation.

It was suggested that police officers should be separated before they prepare their first accounts, and should not be able to prepare their later detailed accounts together. It was also proposed that first accounts from officers should be taken by our investigators or under our supervision; and that this should be carried out as soon as possible after we arrive at the scene.

"The IPCC has failed to recognise that [conferring] is an issue that remains to be addressed and has been passive both in identifying the issue within individual Article 2 investigations and in relation to national guidance. PALG is aware that in some circumstances there will be operational reasons for officers to remain in contact following a death, for example if a further suspect remains at large. Such cases will be very much the exception and if there is such a need officers can be separated once the operational imperative has passed."

Police Action Lawyers Group (PALG)

We are clear that best evidence is obtained where officers separately provide their accounts of an incident immediately after it happens (or as soon as operationally possible). As recent cases have shown, it also adds to the credibility of these accounts if witnesses provide corroborative detail independently.

The draft guidance that we have now issued for consultation under Section 22 of the Police Reform Act sets out our expectation that when there is a death during or after police contact, key police witnesses should be separated before providing their accounts and should not confer.

The current post incident management procedures are designed not only to gather initial accounts but also to ensure that appropriate support is provided to officers and staff – as the police service has a duty of care to staff who have been involved in, or witnessed, a traumatic incident. The importance of providing this support was raised by some police forces and IPCC staff in their responses to the review. It was also acknowledged in Dr Casale's review of our investigation into the death of Sean Rigg.

We agree that it is important to provide such support to officers and staff, but consider that this can be done separately within a framework that guards against conferring. Our statutory guidance will not prevent this from happening.

5

Conducting the investigation

This chapter considers how the IPCC conducts its investigations after the initial actions taken to preserve and collect evidence at the scene. It covers the feedback gathered during the review and our response in relation to:

- approach, planning and oversight of investigations
- operational guidance
- collecting evidence from third parties
- interviewing police officers and others
- assessing and probing evidence
- specialist skills and expertise
- investigating discrimination

We recognise that engaging effectively with families and others throughout is a key part of our investigation, and so we discuss this separately in chapter 6.

Background

Each independent investigation is led by an IPCC investigator, supported by a team including other investigators and support staff, lawyers, and communications staff.

The investigation is overseen by a commissioner who has ultimate responsibility. The commissioner provides strategic direction, scrutinises the investigation, and makes key decisions.

At the beginning of an investigation, the lead investigator drafts terms of reference, which set out the purpose of the investigation and what it will consider. The commissioner is responsible for approving the terms of reference for the investigation and ensuring that they are met before the investigation is concluded.

In an independent investigation, our investigators have considerable powers. If there is a criminal aspect to the investigation, they can arrest, interview under caution and apply for search warrants or to use covert investigative powers. In all investigations, they can require forces to produce evidence or documentation and require officers to attend interviews.

We use these powers during the investigation to obtain and analyse evidence to establish all the circumstances of the death. This may involve taking witness statements, analysing CCTV footage, forensic analysis, and the use of experts to provide opinion on the evidence.

Our response to evidence

There were concerns about the powers and resources we have, but also criticisms about the way we use them. In many cases, these concerns have also been raised internally by staff and commissioners and we are already changing the way that we work.

Some of the key actions that we are taking to improve the effectiveness of our investigations are set out on the following page.

IPCC response at a glance

Conducting the investigation

Principles:

- ➜ Our investigations are, and are seen to be, independent, thorough and as timely as possible, dealing with all relevant issues.
- ➜ Police officers and staff should, as public servants, cooperate fully with our investigations and our search for the truth.
- ➜ We use our powers appropriately and effectively to carry out robust and thorough investigations.

Actions:

- We will develop the standard use of investigation plans in our investigations.
- Staff have received additional training on the threshold for making decisions on criminality or misconduct, and on other matters relating to the use of our powers.
- We delivered additional training for investigators in carrying out probing interviews, focusing on the lessons learned from Dr Casale's review. We also now transcribe all significant police witness interviews.
- We have expanded the use of multi-disciplinary working, and issued new guidance on the role of the commissioner, to ensure robust internal challenge and analysis of evidence.
- We are using our power to require officers to attend witness interviews as soon as possible after the incident. We have proposed to the College of Policing that cooperating fully with investigations should be part of the proposed code of ethics for police officers and staff. If we do not get effective cooperation, we will initially raise this with forces, and will consider whether further action or powers are needed.
- We will exercise powers under the Anti-Social Behaviour, Crime and Policing Bill, when it becomes law, to obtain information from non-police individuals and organisations.
- We will revise our guidance to police on dealing with discrimination allegations, and ensure that terms of reference actively consider discrimination issues. We are providing ongoing training to our staff on dealing with issues of discrimination.
- We will reflect the actions and principles in this report and Dr Casale's review in our new operational model. The new model will make our structures and processes more flexible and support timeliness and quality assurance. That will include external review.
- As part of our new operating model, we will ensure that we effectively use specialist expertise, both internally and through external support in areas such as forensics, mental health and discrimination.

5.1 Approach, planning and oversight of investigations

Stakeholders who took part in the review pointed to the fact that we do not consistently deliver thorough and robust investigations into deaths.

Consultees from various sectors – including families and police – said that, where there are weaknesses, it is because the collection and analysis of evidence during an investigation is unsystematic and lacks both depth and robustness. Concerns were raised about insufficient attention to detail and a failure to gather and collate all evidence or to pursue all reasonable lines of enquiry.

Families, their representatives and police officers criticised us for taking too long to complete investigations, leading to added stress for all involved. Delays in the collection of evidence in particular were seen to undermine the effectiveness of investigations and the confidence of families and the wider public.

"Quite naturally a significant focus of the early part of any independent investigation is to secure, preserve, assess and analyse truly independent evidence (such as CCTV product, public witness trawls etc). At times, this detracts from the sometimes equally relevant lines of enquiry of properly securing key police officer evidence."

ACPO Professional Standards

There is no doubt that a reduction in our resources and an increase in demand for our work have put a strain on the timeliness and sometimes the quality of our investigations. However, the concerns about how we undertake investigations are not wholly because of a lack of resources. Even within our current resources, we must provide the best service possible.

The steps we are taking to improve our scene management capability and expertise will help ensure a systematic approach to the collection of evidence from the start of the investigation (see section 4.2, *Post-incident management*).

We will also be developing a more organised approach to creating, implementing and reviewing investigation strategies. All key strategic and tactical decisions made during an independent investigation must be recorded, but we have not always produced investigation plans that show how information is to be gathered, and the investigation is to be progressed, in order to meet the terms of reference. **In order to ensure quality and timeliness in investigations, we will develop the standard use of investigation plans in our investigations**. The investigation plans will be working documents, subject to ongoing revision, and will be used as a critical tool for case supervision, commissioner oversight and investigation reviews.

We have also improved the oversight of investigations by reinforcing the role of the commissioner in reissued guidance.[21] We will ensure that this is highlighted in our meetings and communication with families, as many of the family members we spoke to told us that they were unclear about the commissioner's role in the investigation. For particularly contentious cases, including deaths, a senior investigator has management oversight of the investigation and advises on investigation strategy. This complements the supervision of cases by managers and through periodic internal investigation reviews.

During the review, there were criticisms both of frequent changes of lead investigator and of ineffective case handover systems. We agree that effective and timely investigations require continuity of key roles. Maintaining continuity has been a challenge owing to increasing pressure on our investigative resources. However, we have recently recruited a significant number of new and trainee investigators and our increased resources will make us better able to prioritise continuity.

We have recently introduced ten operational quality standards[22] that apply to our investigations and other operational work. These standards reflect our commitment to improve the quality of our work overall including our investigations. They include the following:

- We set clear frames of reference for our work, minimise delay, focus on the key points, and take full and proper account of all the available and relevant evidence.
- We understand and correctly apply the relevant law, policies and guidelines, and use our powers appropriately, including keeping information and evidence safe.
- We set out the evidence we have found clearly and show how we have come to our conclusions. Where they require action, we follow through and make sure that changes happen.
- We aim to learn from what we do, and continuously improve our practice, including paying attention to criticism, apologising for our mistakes, and doing our best to put them right.

As we gain more resources, we will have more investigators, greater flexibility and expertise. We will create a specialist assessment function, and a single operational directorate. Together with improved performance management processes and quality standards, this will help ensure that cases are allocated appropriately and progressed effectively. We will develop and use external review, which has proved very valuable in individual cases, as a routine part of our quality assurance processes.

21. View the guidance on the IPCC website: www.ipcc.gov.uk/Documents/investigation_commissioner_reports/Commissioner_Role_in_Independent_Investigations.PDF
22. View the quality standards on the IPCC website: www.ipcc.gov.uk/page/quality-and-service-standards

5.2 Operational guidance

Families, police, and other respondents with direct experience of our investigations into deaths reported significant inconsistencies in our approach to and delivery of investigations. A number of stakeholders suggested that there was a need for more publicly available guidance on how we conduct investigations to clarify roles and procedures.

"Greater clarity in the form of published protocols, agreements and guidance would assist to maximise understanding and use of existing powers."

INQUEST

We have an operations manual for our investigations staff. The manual has developed over time and includes detailed guidance in some areas but is less comprehensive in others. **As part of our change process, we are developing a new operational model, which draws on the work of this review and Dr Casale's report. We will then update and publish our operations manual so that our practices can be understood and scrutinised**.

5.3 Collecting evidence from third parties

We have taken action to remove barriers to collecting evidence that we need for our investigations from third parties (i.e. individuals and organisations other than those subject to investigation).

Under the Data Protection Act, organisations are restricted in what personal information they can disclose. This has sometimes meant that they cannot disclose information to us, or are delayed in doing so, even if they wish to cooperate with the request. If they are reluctant to provide us with evidence they have, we have not previously had the power to direct them to do so.

A number of stakeholders (particularly police respondents) identified this as a barrier to conducting effective investigations. **To address this issue, we will exercise our new powers under the Anti-Social Behaviour, Crime and Policing Bill, when it becomes law, to obtain information reasonably required for the purposes of an independent investigation**.

5.4 Interviewing officers and others

Several stakeholders (voluntary and community, statutory and IPCC staff) suggested that we have, in general, been reluctant to make full use of our powers, and in particular that we under-use our powers to interview police under caution or arrest them. Some suggested that this is because we fail at the start to classify cases as potentially involving criminality or misconduct.

This was said to prevent us properly gathering evidence, affecting the overall adequacy of the investigation and families' confidence in the effectiveness and impartiality of the IPCC. There was also a strong perception among families and voluntary and community sector respondents that police officers receive more favourable treatment than members of the public.

"The IPCC's powers to arrest and interview under caution are triggered on a relatively low threshold. Yet the IPCC routinely fails to utilise this power even in the most serious use of force cases... The reluctance to use this existing power needs to be examined and understood in order to identify how such a contentious failure to act can be remedied."

INQUEST

We agree that we must use our powers rigorously and consistently, including the power to interview police under criminal or misconduct caution where there is an indication of a crime or misconduct. These powers are used on a case-by-case basis, in accordance with the evidence and in consultation with the lead commissioner and we have taken steps to ensure that there is a consistent approach to and rationale for these decisions.

The commissioner must be satisfied with the decision and rationale given by the lead investigator and it is important that this decision is kept under review as the investigation proceeds and is revised as new information comes to light. **There has recently been in-house training for investigators and commissioners in relation to determining whether there is an indication of a crime or misconduct so that officers are interviewed under criminal or misconduct caution**.

Not all deaths following police contact will involve an indication of misconduct or criminal behaviour by police officers or staff. Obtaining and probing accounts from police who witnessed the circumstances of the death is also vital to an effective investigation. The best way to probe the accounts of key police witnesses is through interview. However, in the past, we have faced resistance from some police witnesses to attend interviews, with officers providing written statements instead. This has seriously affected our ability to effectively scrutinise the accounts given.

We welcome the recent change to the law that requires officers to attend witness interviews and note that this change was largely welcomed by respondents to the review. **When we are investigating a death, we now ask significant police witnesses to attend an interview shortly after the incident (referencing our power to compel officers to attend). This approach is set out in the IPCC significant witness policy**[23] **and IPCC police witness policy**.[24]

In practice we have not had to use this power in most cases, as officers have chosen to attend rather than being compelled to do so. However, in some cases, police officers and staff are being advised by the Police Federation or their legal representatives, to attend but not answer questions, and are offering instead to provide written statements.

We do not have the power to compel officers to answer questions at interview. Some stakeholders suggested that we should be given this power.

A number of police consultees warned against our increasing use of formal powers in investigations. It was suggested that officers often perceive us to be investigating them rather than the incident, that this could hinder cooperation, and that officers' rights as citizens need to be respected.

"I believe the powers currently at the disposal of the IPCC are sufficient to allow them to discharge their functions, but provide a note of caution that the policing culture is complex and far more can be gained by negotiation and discussion than the use of coercive powers."

Bedfordshire, Cambridgeshire and Hertfordshire forces

It was also strongly argued by police respondents that there would be greater cooperation if there was more clarity early in an investigation about whether or not an officer would be treated as a suspect (criminal or misconduct) or witness.

We expect police officers and staff, as public servants, to cooperate fully with our investigations and our search for the truth. Other professions – doctors, nurses and social workers – are obliged, under their professional codes to do so. It is unacceptable that some officers who are immediate witnesses to a death during or following police contact do not answer questions at interview and therefore appear reluctant to cooperate fully with our investigation.

23. View the IPCC significant witness policy online: http://www.ipcc.gov.uk/Documents/guidelines_reports/IPCC_Significant_Witness_Policy.pdf
24. View the IPCC police witness policy online: http://www.ipcc.gov.uk/Documents/guidelines_reports/IPCC_Police_Witness_Policy.pdf

Many respondents to the review expressed their disbelief and dismay that officers refuse to answer questions in these circumstances. This clearly has the potential to undermine public confidence in the police and risks compromising the robustness of the investigation and delaying answers for the family and community.

The College of Policing has recently carried out a consultation on a draft code of ethics for the police. In our response to this consultation, we argued that ethical policing is about what officers should do, not just what they should not do. In particular, we consider that this includes cooperating fully and promptly with the investigation of any complaint, conduct matter or death or serious injury matter. **We have recommended that the proposed code of ethics for police personnel includes a positive obligation to cooperate fully with our investigations, especially when the investigation concerns the most serious incidents, such as when someone has died in police custody**.

The decision about whether an officer is a suspect or witness in an investigation is subject to review and possible change as an investigation progresses and new evidence comes to light. We will seek to prevent any misunderstanding, by making clear to officers who are being interviewed as witnesses that although they are being treated as witnesses, their actions, omissions, statements and decisions will be under scrutiny during the investigation. Improving communication with officers involved in an investigation is discussed more generally in chapter 6, *Engagement during investigations*.

We will monitor and report on the impact of our power to compel officers to attend witness interviews, including any refusal to answer questions at interview rather than later in writing. We will raise this with chief officers and police and crime commissioners, and refer to it in our reports and public statements.[25] We will also indicate areas that the coroner may wish to explore when witnesses are under oath at inquests.

We do not wish to ask for additional powers at this time, and we would much prefer to act with the cooperation of police witnesses; but we will keep this matter under review. **If we believe that our investigations are being unduly hindered or undermined by lack of cooperation we will consider seeking further legislative changes**.

25. See, for example, the press release in Derbyshire case: www.ipcc.gov.uk/news/investigation-continues-police-officers-decline-answer-ipcc-questions-during-witness-interviews#sthash.PYfll4JU.dpuf

5.5 Assessing and probing evidence

A number of stakeholders from voluntary, community and statutory organisations, as well as families, said that we should consistently use greater rigour in the assessment and probing of evidence – particularly police accounts. Criticisms included a lack of robustness in questioning witnesses, and a failure to address conflicts and gaps in evidence, including discrepancies between accounts.

"Time and again we see the IPCC accepting police evidence at face value, preferring it and drawing conclusions that are favourable to the police without any critical evaluation."

Police Action Lawyers Group

Similar concerns were raised by Dr Casale in her review of the investigation into the death of Sean Rigg. She raised particular concerns about a lack of critical questioning of police accounts during interviews.

"The interviewers did not pursue failures on the part of the police with sufficient rigour (e.g. the police officers' failure to establish that the passport was Mr Rigg's and their failure to recognise indicators of mental illness). Most of the interviewers appeared ready to accept the police officers' view of events without following up potential lines of questioning."

Dr Silvia Casale, Rigg Review

Conducting probing interviews (of suspects and significant witnesses) that unpick, question and, if necessary, challenge the accounts given is vital to conducting an effective investigation that can stand up to public scrutiny.

All IPCC investigators are now required to demonstrate evidence of good quality interview techniques as part of their initial investigator accreditation. **In December 2013 we delivered additional continuous professional development training for investigators in conducting probing interviews focusing on the lessons learned from Dr Casale's review.** This training was run in all of our offices and the majority of our investigators took part.

We have also increased our capacity to transcribe interviews. **We now transcribe all significant police witness interviews (in addition to suspect interviews) in investigations into deaths following police contact**. This allows improved analysis of evidence and assists managers to assure the quality of interviews and identify any development needs.

Families and their representatives also raised concerns about the amount of information disclosed to police personnel before interview. This was said to be unfair and to risk undermining the effectiveness of the interview and the integrity of the evidence obtained.

"Police officers who are suspects (or witnesses) will routinely be given, through their lawyers, extensive disclosure of material before they are interviewed. The potential for prejudice is quite clear."

Police Action Lawyers Group

Under law, IPCC investigators must provide police interviewed under misconduct caution with information the investigator considers appropriate in the circumstances to enable the interviewee to prepare for the interview.[26] Criminal interviews must be undertaken in accordance with the Police and Criminal Evidence Act 1984 and the relevant case law and codes of practice. Disclosure within these legal requirements is a matter of judgment for the investigator. However, it is clear that public confidence would be undermined if the extent of the disclosure given to suspects (or witnesses) was perceived to give the interviewee an unfair advantage or to undermine the integrity of the account given. **We will review our guidance for investigators on pre-interview disclosure to ensure that it reflects the findings of this review and supports the collection of best evidence.**

5.6 Specialist skills and expertise

In general, we are moving towards greater multi-disciplinary working in investigations. As stated previously, we have strengthened the role of the commissioner and ensure that all investigations have early input from a lawyer. **We plan to extend this multi-disciplinary approach in complex investigations under the new operating model for an expanded IPCC, drawing on a greater range of internal specialists**. In doing so, we hope to ensure that the cases we investigate are considered from a range of different perspectives to support lead investigators' abilities to challenge, question and probe.

This also requires knowledge of policing practice (such as police restraint techniques or use of firearms) and investigation techniques (such as interviewing and crime scene management). It also requires knowledge from outside policing in relation to issues such as restraint, discrimination and mental health. In addition, investigators will need to have knowledge and understanding of the broader context around the death, such as the role of other services (e.g. health and social services).

26. Regulation 19, Police (Complaints and Misconduct) Regulations 2012.

"There's a question about how the organisation is building itself up to perform the distinct function that it plays. It's policing within a social context... and therefore that cuts across... social services, mental health, the police... – it's right across. The IPCC has to have an understanding of that context."

External stakeholder – NatCen research

Stakeholders from various sectors (including the police) suggested that we lack specialist skills and expertise in some of these areas and that there should be improved training and professional development of IPCC staff.

"The IPCC should expand its capability in all areas of expertise, to reduce the necessity to use police resources."

Greater Manchester Police

It was also suggested that we could make better use of the considerable internal expertise that we have built up over the last ten years, drawing on evidence and findings that have emerged from previous investigations and deaths in similar circumstances to identify whether there are patterns of concern and whether learning has not been embedded in practice.

There was also a widespread call – from voluntary, community and police respondents in particular – for us to make greater use of a wider range of external experts, particularly in health, discrimination, mental health, substance misuse and gender-based violence. Voluntary sector and local community-based groups were described as sources of external expertise that we could make more use of.

"We believe seeking advice from independent experts is important, particularly given the stigma and misperceptions about mental health within the police service."

MIND

Some stakeholders (mostly but not exclusively voluntary, community and families) called into question the quality and independence of the expert evidence that we currently rely on. There were particular concerns about relying on current or former police officers as experts in reviewing the use of restraint or other force by the police. There were also perceptions that the process for appointing experts is not sufficiently systematic and transparent. These problems can have serious implications for the overall quality of investigations and confidence in outcomes.

While many stakeholders called for more use of external experts, there was also some cautioning against over-reliance on the opinion they provide.

"There is a tendency to use such expert opinion in place of the IPCC investigator's own critical analysis/independent judgment, in particular in relation to 'use of force' experts."

Police Action Lawyers Group

There will always be circumstances in which our investigations benefit from opinions given by external experts on specific issues. However, any opinion given by an expert witness will not itself determine the findings of our investigation. **Our decisions will be based on our assessment of the evidence, with all evidence (including expert witness opinion) subject to critical scrutiny and analysis**. For this reason, we need to ensure that we have the right balance between developing internal skills and expertise and engaging external experts for our investigations. Even when advice is sought from external experts, our staff need to have sufficient knowledge and skills to know what questions to ask and to critically analyse the assessment offered by the expert.

As we develop the new operating model for an expanded IPCC we will review the role of internal and external expertise in our investigations. This will include how we source and instruct external experts. One suggestion, put forward by several stakeholders, and which we will explore further, was that we should set up panels or a published database of approved experts, appointed through a transparent process.

It is important to note that when we are considering possible criminal allegations in an investigation we need to ensure that any external experts engaged will satisfy the requirements of the Crown Prosecution Service (CPS) for any resulting prosecutions. We will therefore work closely and discuss with the CPS as we review our process for sourcing and using experts.

5.7 Investigating discrimination

Concerns about the rigour of our approach in identifying whether discriminatory behaviour may have been a contributing factor in a death, as well as the confidence of our investigators in identifying and addressing such issues, were raised both in this review and Dr Casale's review. It was argued that IPCC investigations do not adequately address central contentious features of many cases, such as race, disability and mental health, and the overlaps between these. Respondents identified a need for better training for IPCC staff on diversity issues – particularly in relation to race and ethnicity, mental health, and learning disabilities.

"The lack of reference to race throughout is not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately."

Dr Silvia Casale, Rigg Review

When we develop the terms of reference for investigations into deaths we will, in all cases, consider whether there are discrimination issues that require investigation. In addition, we are providing ongoing refresher training for both investigators and casework managers on dealing with allegations of discrimination. This will be complemented by training in challenging personal bias (as outlined in chapter 2, *IPCC independence*). **We will also revise our guidance to police on dealing with discrimination allegations**, drawing on the findings of this and Dr Casale's review, as well as the work we have done on the Metropolitan Police[27] and other forces' handling of such complaints.

Mental health is a major underlying issue in many deaths we investigate. In 2012/13 approximately half of all those who died in police custody and almost two-thirds of those who apparently took their own lives afterwards, were known to have mental health concerns.[28]

The importance of incorporating a service user perspective in the work of the IPCC has been strongly put forward by community and voluntary sector groups. **We are taking steps to increase our own knowledge and awareness about current mental health issues, and will review staff training in mental health awareness, incorporating service user experiences**. This will be supplemented by making greater use of specialist expertise, both internal and external, when required for particular investigations.

27. View our report on Metropolitan Police Service handling of complaints alleging race discrimination online: www.ipcc.gov.uk/Documents/investigation_commissioner_reports/Report_on_Metropolitan_police_Service.PDF

28. www.ipcc.gov.uk/news/ipcc-publishes-annual-deaths-during-or-following-police-contact-201213-%E2%80%93-mental-health-key

6

Engagement during investigations

This chapter considers the way we engage during an investigation, both with those directly affected by the investigation, and with those who have an interest in our work, including the local community and the general public. Effective engagement with, and involvement of, bereaved families is an important part of our responsibility under Article 2, and has therefore been one of the focuses of this review. Fundamental to this engagement is enabling a family's effective and meaningful involvement and contribution at all stages of the investigation process.

6.1 Engaging with families

This section considers the evidence gathered during the review about how we engage with bereaved families in an investigation into a death. It includes:

- our overall approach to engaging with families
- family liaison roles
- involving and updating families throughout the investigation
- getting feedback and learning from families' experiences

Background

The sudden death of a family member or close friend is a hugely traumatic event, particularly when they have been in the care of the state. It is essential that families trust that we will carry out a robust and thorough investigation, and that they are as involved as they can be, or want to be as our work progresses. The investigation should seek to answer the questions they have about how and why the person close to them died. That is why family involvement is a specific requirement in any investigation into a possible breach of Article 2 of the European Convention on Human Rights. When someone dies during or following police contact, the local police force are the ones who will inform the next of kin, as they can do this most quickly. As soon as we decide to carry out an independent investigation, we will contact the family as soon as possible, and offer meetings with the commissioner and lead investigator to explain our role and what we will be doing. We will also provide information about their right to legal representation and where to go for independent advice and support. In some cases, we will appoint a family liaison manager to act as a link between the investigation and the family.

During the course of the investigation, we must keep families informed, providing them with meaningful updates and as much information as we can, and giving them an opportunity to ask questions and comment on what we are doing.

Our response to the evidence from the review

Some of the strongest criticism during the review was about the way we have engaged with bereaved families in our investigations into deaths.

We accept that we need to improve our relationship and engagement with families as a matter of priority, to ensure that we are responsive and sensitive, and that families can be engaged in the investigative process.

The principles we will apply and the actions we are taking are set out on the next page.

IPCC response at a glance

Engagement with families

Principles:

- ➜ Families are as involved as possible in our investigations and provided with the information and support they need to do this.
- ➜ Our investigations seek to answer the questions the family has about what has happened to the person who died.
- ➜ Our engagement with bereaved families is carried out in accordance with the family liaison common standards and principles[29] endorsed by the Ministerial Board on Deaths in Custody. This means that we will:
- – be respectful and responsive to families' needs, acknowledging that they are grieving
- – provide regular updates about the investigation and timeframes, agreeing the frequency and method of contact with the family
- – be clear about roles and the point of contact for the family
- – be clear about how information provided by the family will be used
- – provide families with information about relevant support and legal services that they can access
- – provide staff with appropriate training, including training in engaging with bereaved families

Actions:

- We are providing training on bereavement awareness and the stages of grief to all investigators and commissioners. Performance reviews for investigations staff will include assessments of their work with families.
- As part of expansion, we will develop a new model for family liaison, drawing on the feedback from this review. This will be informed by a victim support approach.
- We have revised the initial information we provide to families and the letters they receive. We are developing a more detailed information pack to supplement this.
- All families will have the opportunity to meet IPCC staff and commissioners at the beginning and throughout the investigation. They can ask any questions and voice any concerns about the investigation's progress or approach.
- We will involve families in developing the terms of reference for the investigation so that they include the questions that the family wants us to try to answer.
- All press statements will be agreed in advance of circulation, wherever possible, with families.
- We keep families updated on the progress of the investigation, disclosing all information, subject only to the 'harm test' (detailed later in the chapter). As we develop investigation plans, we will share them with the family. We will also explore providing them with draft reports.
- We are carrying out a review of all our methods for seeking feedback. This will include how we seek regular feedback from families and their representatives to improve our work with families.

29. Read the family liaison common standards and principles online: http://iapdeathsincustody.independent.gov.uk/news/family-liaison-common-standards-and-principles

Discussion of the evidence and our response

Approach to engagement with families

The listening days organised by INQUEST and interviews with families undertaken by NatCen allowed some bereaved families to express their strong feelings about poor or insensitive practice in our interactions with them.

The families who responded to the review gave examples of where our communication had lacked empathy, sensitivity and compassion.

"They [the IPCC] have got to understand when they're talking to people, they're looking at it from an investigation point of view... but it's also about not losing focus on [the family member] as a person as well... I find some of these meetings quite hard. I know it's just a job for them... its like once the discussion is finished there can be banter and things like that... They've got to remember that it's another case [to them]... but it's also a person."

Family member – NatCen interview

Some families also felt that they and those who had died were wrongly characterised or unfairly judged. In some cases, families felt that they themselves were under investigation.

"We felt we were being judged, and intimidated by the investigating officer."

Family member – INQUEST Family Listening Day

Families explained that negative experiences made family members suspicious of the IPCC and doubtful about the organisation's capacity to carry out an effective investigation.

Some families reported examples of good practice in our engagement with them.

"Our family liaison manager was always on the end of the phone when needed and explained if and why he could not answer a specific question."

Family member – INQUEST Family Listening Day

Good practice included IPCC investigators:

- offering their condolences
- explaining their role and the process of investigation
- answering the family members' questions or setting a time frame for responding if they could not do so immediately
- establishing the best way to stay in touch

However, it is clear that this has not consistently happened.

We know, from the families we have heard from, that where we have been able to establish and sustain good and professional relationships with families, and properly taken on board family concerns and grievances, this has had a positive effect on trust in the investigation.

To achieve this, **we need to be professional, respectful, sensitive and responsive to families' needs. In particular, all our dealings with families need to be informed by the understanding that they are grieving and have experienced a sudden and unexpected bereavement in highly traumatic circumstances**. Indeed, they are probably going through the worst experience of their lives.

In the past, training on working with bereaved families was focused on family liaison staff. However, the feedback received from the review has emphasised the need for all investigations staff and commissioners to be provided with this training. The relationship with the family and their representatives must be at the centre of their work, and is crucial to ensuring the effective involvement of the family in the investigation. **We are providing training on bereavement awareness and the stages of grief to all investigators and commissioners**. Training on engagement with bereaved families is also included as a required module in the standard training package for new investigators. We need to be aware of how prolonged and lengthy investigative and coronial processes affect the bereavement process.

We would like to work with INQUEST to develop this training further. Some family members who have contributed to the review have expressed an interest in taking part in this training. We agree that including a family perspective would be a powerful and effective way of improving practice and we will explore how we can involve families in the future, if they wish to do so.

As previously stated, we have recently introduced ten operational quality standards[30] that apply to our investigations and other operational work. These standards reflect our commitment to put families and complainants at the heart of our work. They include:

- We are polite, helpful and accessible. We try to understand the key issues and the outcomes that people want; set and meet realistic timescales and keep them updated on progress; and explain our decisions.
- We communicate effectively, by writing and speaking in good, plain English, taking account of the needs of the reader/hearer, including showing empathy to those who are distressed.

We will monitor our performance against these quality standards. As part of this, the **performance reviews for all investigations staff will include an assessment of their work with families and how it meets these standards**. Investigators will reflect on their relationship with individual families during regular meetings with managers and include an assessment of the effectiveness of those relationships in investigation updates to the commissioner.

30. View the quality standards on the IPCC website: www.ipcc.gov.uk/page/quality-and-service-standards

Family liaison roles

Stakeholders generally felt that the IPCC family liaison manager role can make an important contribution to effective engagement with families.

However, it was felt that there should be greater clarity and consistency in how this role is defined and deployed, and that it needs to be better resourced and valued.

"We want our experience of the IPCC to be consistent, it feels like at the moment experiences are random, and a positive experience is down to chance."

Family at INQUEST Listening Day

It was also recognised that it takes considerable skill to engage effectively and appropriately with families who have been bereaved in traumatic circumstances.

We will review the way we provide family liaison as the organisation grows and changes. This was welcomed by families who attended the consultation event in October 2013. Some families felt strongly that we should not confuse our investigative role with one of support; on the other hand, some believed that liaising with families should be embedded in our whole approach – 'in its DNA', – rather than having a specific role.

We will consider the feedback provided during the review as we develop a revised model for family liaison. Importantly **the new model will recognise that families need the same kind of support as victims**. Good family liaison is not just about being sensitive to a family's bereavement but also being aware of how a negative experience of the procedures and investigation that follow a death can contribute further to their distress. We will prioritise the provision of assistance and support throughout the investigation and ensure that families are kept properly informed of the progress of the investigation and can effectively engage with the investigation process.

Involving and updating families during the investigation

We are taking action to improve our work with families at each stage in the investigation process. Families and voluntary/community sector stakeholders stressed that open and sensitive early contact in an investigation is crucial, even though this is the most difficult time for families.

"Meaningful communication and engagement from the outset, which properly takes on board family concerns and grievances could do much to re-frame the often fraught relationship with families."

INQUEST

However, families reported a lack of sensitivity and also confusion in our approach. This included being overwhelmed with information, and that the timing or location of initial meetings did not take account of their needs and expectations. Families and some voluntary/community stakeholders told us that when commissioners engaged with the family, this had a positive impact on trust and helped to create the sense that the family and the investigation were valued. **All families will be given the opportunity to meet the commissioner at the beginning of the investigation**. Some families may not feel ready to do this at this stage, and if they do not initially take up the opportunity to meet, the offer will be made again at intervals during the investigation. This commitment is set out in the new guidance for commissioners,[31] issued in February 2013.

The process for investigating a death following or during police contact can be complex and lengthy. As well as the investigation itself, it will involve a post-mortem, almost always an inquest and may also involve disciplinary and/or criminal proceedings. In some cases, matters raised at inquest may lead to further investigative work or further proceedings.

Families explained the difficulty of navigating this process and the importance of being given clear information about the different stages and what to expect. A number of families reported that we provided insufficient or inaccurate information about the investigative process, timelines, the respective roles and responsibilities of our staff, and external sources of support for families.

We have reviewed the initial letters and information we provide to families. We are developing a more detailed and comprehensive information pack to supplement this. This proposal was welcomed by families at our consultation event in October 2013. We will incorporate suggestions about what to include, such as:

- links and information about the specialist advice and support provided by INQUEST and about other sources of support, including bereavement support and legal advice
- full details of the key individuals involved in the IPCC investigation, such as the lead investigator and commissioner
- a quick reference or 'emergency' page that people can access if they are not yet ready to read all the information in the pack

We will consult organisations providing support to bereaved families about the content of the pack.

The families who took part in the review largely felt that they were not appropriately updated and involved throughout the investigation.

Families and voluntary/community stakeholders made it clear that families want regular, open and meaningful updates from us on the progress of investigations, rather than standard format letters; and that when action or information was promised by a certain time, it should be provided or an explanation given. It was also suggested that we should ask families how they would like to be involved in the investigation, recognising that each investigation and each family is different.

Some stakeholders described positive experiences of contact between families and IPCC staff; reflecting a willingness on our part to work closely with the families. Others, however, said that they found it difficult to make contact with us, and that there was a lack of response or evasive responses to questions asked.

"Letters and questions put to the IPCC were not answered. Responses, when and if received, were evasive and defensive and did not answer the questions put to them. In some cases they purported to be answering the questions, but in fact provided statements that were at tangents to the questions asked and were not responses to the questions at all."

Family member – INQUEST Family Listening Day

It was suggested that the important contribution and added value that families could offer throughout investigations should be recognised. Families felt they were being 'told' rather than listened to, involved in discussions or seen as a partner in the investigation.

Families said they wanted more input into the development of terms of reference and the direction of the investigation. In some cases families felt that they had had no part to play in this process.

"[The IPCC] wanted to run the investigation without any input from us at all."

Family member – INQUEST Family Listening Day

Families and the organisations that support them also strongly argued that families should have the chance to comment on the emerging findings and draft investigation reports to ensure that their questions had been answered before the investigation is finalised. They gave the example of the Prisons and Probation Ombudsman, which provides families with this opportunity.

As we have said above, it is vital to our investigations into deaths that families are as engaged as they can be, or want to be, in the investigative process, and that we seek to answer their questions.

We will actively seek the involvement of families in developing the terms of reference for the investigation so that the scope of the investigation allows for the questions they have about their relative's death to be answered. We will explain to families that they can continue to raise questions as the investigation progresses, as the terms of reference can be reviewed at any time throughout the investigation. If we are unable to answer families' questions in our investigation, we will clearly explain this, giving reasons.

In the future we will be developing investigation plans that outline the lines of enquiry we will follow to meet the terms of reference. This is discussed in chapter 5, *Conducting the investigation*. Families at the consultation event held in October 2013 welcomed this approach and wanted to be involved in the creation of the plan and any changes made as the investigation develops.

We will share investigation plans with families and discuss any changes during the investigation. We will also use the plan as a point of reference to help us to provide families with meaningful updates about the direction and progress of the investigation.

We will ask families how they want to be kept up to date with the progress of the investigation and respond to this. Families may, for example, want to be contacted through a lawyer or other nominated person and we will agree to do this where requested. We will clearly set out who in the IPCC is responsible for making contact with the family and responding to the families' questions and queries.

We agree that it is important for families to have an opportunity, before an investigation is finalised, to know the emerging findings and to be able to see how their questions have been addressed. **We accept that providing families with the opportunity to see a draft of the investigation report would be an effective way of providing this and we are examining whether and when we could do this, as part of our new operational model**.

Disclosure of evidence to families

A key part of maintaining open and meaningful engagement with families is the timely disclosure of evidence throughout the investigation.

Some families and voluntary/community stakeholders reported inconsistencies and delays in disclosure of evidence, which can cause distress and confusion for families. It was also noted – including by some police consultees – that when information is withheld, this is often not adequately explained, and that this creates a general mistrust of the IPCC.

31. View the guidance on the IPCC website: www.ipcc.gov.uk/Documents/investigation_commissioner_reports/Commissioner_Role_in_Independent_Investigations.PDF

"For a bereaved family trying to engage in an IPCC investigation the organisation's reluctance to provide early and full disclosure (or to clearly explain why they cannot provide this at early stages of investigations and when they expect to do so) fosters mistrust. It is alienating and unhelpful."

INQUEST

We have a legal duty[32] to keep families informed about the progress and provisional findings of an investigation, with some clearly defined exceptions. This is broadly called the 'harm test'.[33] Examples are:

- if non-disclosure is necessary to prevent the premature or inappropriate disclosure of information that is relevant to, or may be used in, any actual or prospective criminal proceedings
- if it is necessary to prevent the disclosure of information in the interests of national security, on proportionality grounds, or in the public interest

Stakeholders from various sectors commented that this harm test has sometimes been inappropriately applied: that it has been used too rigidly or restrictively because of a risk-averse stance on our part, because disclosure is time-consuming, or because of a resistance to providing information to families.

Openness is one of our core values and disclosure of information is one of the ways we ensure transparency in our work. The disclosure of evidence to families in an investigation into a death is also vital if they are to be effectively involved with the investigation.

The process of disclosure, where we must decide if any information should be withheld in accordance with the harm test and then remove or 'redact' that information, can be complex and resource intensive. However, we are clear that **IPCC investigators will begin from the position that families of a deceased person will be given access to information gathered during the investigation**. We will explain to families if we cannot release information to them at this stage, and tell them why.

In some circumstances our hands are tied by the law. One such provision is Section 17 of the Regulation of Investigatory Powers Act 2000 (RIPA). The impact of this is not only that some information cannot be disclosed, but also that we cannot even explain why this is, as this itself would be a breach of the law.

In our view this places investigatory bodies in the impossible position of being unable to provide families and the public with meaningful information on the investigation or even explain why that information cannot be provided. We believe this part of the law needs to be changed.

32. Section 20(1) and section 21(6), Police Reform Act 2002.

33. As set out in regulation 13 of the Police (Complaints and Misconduct) Regulations 2012. For general guidance on how these exceptions are applied, see our Making Information Available policy: www.ipcc.gov.uk/Documents/guidelines_reports/making_information_available-2.pdf

We have publicly called for Section 17 RIPA[34] to be changed so that we and coroners are able to carry out effective and transparent investigations. We will continue to make this case in the future.

Involving families in the drafting of press releases

Families consulted as part of the review raised particular concerns about information released publicly in press releases during the investigation.

We agree that the accuracy of the press release is crucial. Inaccuracies in information regarding relatives' personal details are particularly distressing and could undermine faith in the IPCC and the investigation.

"Whilst [publishing inaccurate personal details about the deceased] may seem insignificant to the IPCC it is very hurtful when going through trauma and grief."

Family member – INQUEST Family Listening Day

Press releases were also criticised for relying too heavily on the police version of events and in some cases creating a narrative that appeared to judge the person who had died. Some families also reported that the IPCC seemed reluctant to address any errors or misinformation included in press releases.

Families wanted the opportunity to comment on press releases and to be given sufficient notice before they are published. One family member described how they had been able to put together a 'family tribute' as part of the press release, which they had appreciated.

We know that when we have made mistakes in the information included in press releases, this seriously damages both the family's and the broader community's trust in us and our investigation.

We have recently taken steps to clarify our approach to issuing press releases in independent investigations. In particular, we are clear that **all press releases about an IPCC investigation into a death will be agreed, where possible, with families or their representatives**. Our operational guidance on working with the media also covers including family tributes or photographs of the person who has died if requested by the family.

Our approach to engaging with the public about investigations through the media is discussed more broadly later in this chapter.

34. See the IPCC website: www.ipcc.gov.uk/news/ripa-statement-ipcc-deputy-chair-deborah-glass

Learning from families' experiences

Families and voluntary and community sector respondents suggested that we need to improve our internal processes to ensure that learning from investigations is identified (drawing on both good and poor practice) and acted on. It was suggested that central to this process should be feedback on the investigation from families and complainants, which should be routinely and proactively collected and analysed to help find out what worked well or what could be improved.

"The organisation should systematically seek feedback from families following an investigation... In addition, the IPCC should consider setting up a Family Panel or Standing Commission of Families to establish a formal mechanism for families to give input or feedback to the IPCC."

INQUEST

We have already made changes. The lead investigator's manager now makes contact with families early in each independent investigation to explain how the families can voice any concerns they have about the investigation or about the approach to engaging with them.

The process of hearing the experience of families through this review has been extremely valuable. **We want to build on this to seek regular feedback from families in the future**.

Families were very positive about the group listening days facilitated by INQUEST as part of the review and suggested that this could be an effective way of seeking feedback in the future.

We are currently reviewing our approach to collecting feedback across all our operational work and will consider the suggestions put forward by families and others in this context. We will also discuss with INQUEST how we can work with them to obtain feedback in the future.

6.2 Engaging with the police force, and police officers and staff

As we strengthen our focus on families and complainants, we must also make sure that we communicate appropriately with police officers and staff involved in our investigations and their forces, and keep them properly informed about progress. Indeed, many of the issues raised by police personnel – timeliness and the quality of communication – were similar to those raised by families. This section considers evidence in relation to our engagement with police forces, officers and staff, subject to or involved in our investigations.

Background

Police forces, as well as officers or staff who are witnesses to an incident or subjects of an investigation, need to trust that we will be fair, objective and professional in our dealings with them and in the search for the truth. A key element of this is clear and timely communication during the investigation.

IPCC response to the evidence from the review

The steps we are taking to clarify and improve our engagement with police forces, officers and staff are outlined on the following page.

IPCC response at a glance

Engaging with the police force, police officers and staff

Principle:

➜ Clear information will be provided to police forces, and police officers and staff subject to investigation, about the scope of our investigation and timeframes.

Actions:

- We will share advance copies of press releases with the press office of the police force involved in our investigation, wherever possible, to ensure factual accuracy.
- As part of the review of our operations manual for investigations we will ensure that investigators are provided with clearer guidance about updating police forces, police officers and staff throughout the investigation.
- We are carrying out a full review of all our methods for seeking feedback. This will include consideration about how best to gather and learn from feedback provided by officers and staff involved in our investigations.

Discussion of the evidence and our response

Many police consultees said that we do not adequately update police forces during investigations, or that communication between us and forces is inconsistent and depends on the commitment of individual investigators. Examples of poor communication included long delays in providing information and failure to update force professional standards departments at key stages such as when files are submitted to the Crown Prosecution Service.

"Experience is that communication with the home force on the progress of the investigation is limited and can be improved. Confidence and reputational issues for forces are significant and the protracted nature of the IPCC investigations can make the management of these matters problematic."

Norfolk and Suffolk Professional Standards Department

Police officers and staff who participated in the review said that they appreciated being contacted by us shortly after a death to be made aware that an independent investigation would be carried out. However, they and the organisations that represent them reported that the quality of information provided varies, and that unclear or incomplete information can cause additional anxiety to officers. It was also strongly argued that police officers and staff involved in an incident under investigation should be given greater clarity about whether they are to be treated as a suspect (criminal or misconduct) or a witness.

Police officers and staff, and those that represent them, said that communication throughout the investigation was particularly poor. Their responses in many ways echoed those of the families we spoke to: that information was not consistently provided, or was not meaningful. Not knowing how the investigation was progressing had a significant emotional impact on some officers and their families, particularly in cases where officers had been suspended or removed from particular duties and when the investigation and related proceedings continued over a long period of time.

"Now I just get once every 12 weeks a letter from the IPCC saying, 'Investigation is still ongoing', and that's basically it. Very frustrating... Under police regulations, they have to give an update at least once every so long and what they do just before that time limit runs out, they'll send a letter, so they can say they've done it but they actually tell you nothing."

Police personnel – NatCen interview

When providing information to police officers and staff who are witnesses to the incident or subjects of the investigation, we must recognise that they themselves may be traumatised by the incident and that the investigation process can be extremely stressful. **We expect and rely on their full cooperation with our investigations. In return, we need to ensure that, as far as possible without compromising the integrity of the investigation, they are kept informed about the progress and likely timescale and any delays are explained. Our new operating model and investigation plans will seek to ensure both timeliness and quality**.

We need to balance the need to preserve the independence and integrity of the investigation with the desire to be open and transparent. It will not be possible to provide full details of evidence or proposed actions to those under investigation, but in most cases information can be provided about the scope of the investigation and timeframes, with regular updates broadly outlining the progress of the investigation against the planned timescale. We will also make clear whether we are treating an officer or staff member as a witness or suspect, though we will explain that this could change during the investigation. Our approach to this is discussed further in chapter 5, *Conducting the investigation*.

Details about the scope of the investigation and regular updates about progress will also be provided to the local force. The steps that we are taking to clarify our role and the role of the police at the scene and throughout the investigation (discussed in earlier chapters) should also assist communication and understanding.

We will be developing a new operational model as part of our change programme. This will result in a revised operations manual, which we will make public. It will provide investigators with clearer guidance on updating officers, staff and police forces throughout the investigation, taking into account the feedback from the review. It will also help others, including police officers and staff, to know what is likely to happen during an investigation and why. More resources, and the other changes proposed in our transition, will also improve the timeliness of investigations, which is a major concern for police as well as families.

In the past we have sought feedback through a survey of officers and staff subject to investigation, but we stopped doing so because of financial constraints. As we grow, we are conducting a comprehensive review of all our feedback mechanisms to improve confidence in the complaints system and our investigations. **We will consider how best to gather and learn from feedback from officers and staff involved in our investigations**.

Police forces and police officers and staff raised particular concerns about the information included in press releases. They felt that we take insufficient account of the views of the force concerned before releasing information to the media. It was also felt that media releases can be unbalanced, by being too negative, defensive and/or emotive. This was felt to have a negative effect on public confidence in the police, community relations, and the welfare of officers under investigation.

"There have been a number of instances where the IPCC press release has placed additional pressure on a police force due to the structure, which does nothing to play down public perception that the police are at fault and can actively fuel this view. The IPCC needs to work closely with forces when preparing and releasing information to the media. This is not for the sake of playing down the issue, but ensuring that content is not only factual, but also sensitively worded."

South-West Regional Professional Standards Group

In April 2013, we agreed a new media protocol with the Association of Chief Police Officers (ACPO), setting out our roles and responsibilities, and those of police forces, in dealing with the media during an IPCC investigation. The protocol states that we will **share advance copies of press releases with the press office of the police force involved, wherever possible, to ensure factual accuracy**.

6.3 Engaging with communities and the public through the media

This section considers the evidence gathered in the review and our response in relation to:

- engaging with communities and community representatives
- engaging with the public through the media

Background

Engagement with communities and the wider public during an investigation has important implications for confidence both in our investigation and in the police complaints system as a whole.

Our response to the evidence from the review

The steps we are taking to clarify and improve our engagement with communities and the public are outlined below.

IPCC response at a glance

Engaging with communities and the public through the media

Principles:

- ➜ Where an IPCC investigation into a death raises significant community concerns, the lead commissioner will consider how to engage with the community, recognising the importance of community confidence and trust in ourselves and the police.
- ➜ We will be proactive and responsive in our approach to engaging with the media about our investigations to ensure that information published about the investigation is accurate, and any misinformation is addressed promptly.

Actions:

- We will seek to develop better links with people and organisations who work in the community, including groups that have low levels of trust in the police and the complaints system. We will use these links to help identify appropriate representatives for involvement in individual investigations (e.g. through community reference groups).
- We will explore greater use of social media such as Twitter. This allows us to communicate directly to the public in dynamic and fast-moving cases and to correct or clarify misleading coverage promptly and robustly.

Discussion of the evidence and our response

Some voluntary and community stakeholders, as well as many police respondents, said that we should be more proactive and robust in carrying out community engagement: in other words, promoting our profile and helping to build trust in local communities. Suggestions included holding public meetings or community briefings to update local communities on the progress of investigations; enhancing our visibility at times of crisis, such as after public order disturbances; exploring potential feedback processes with police and crime commissioners; and working more closely with local forces to address community tensions. It was also suggested that we should engage more proactively with marginalised groups in local communities, including young people, members of black and minority ethnic communities, and people with mental health problems.

Many police and some other consultees suggested that we should make use of the police's independent advisory groups (IAGs) and other existing structures, rather than trying to set up new ways of consulting.

"Work within communities by the IPCC needs however to be built on a real concept and understanding of that specific community, their needs and the challenges facing them. To aid this, the IPCC could develop direct links with community Independent Advisory Groups."

Greater Manchester Police

The establishment and use of community reference groups (CRGs) was thought to be a valuable way of building public confidence and improving the effectiveness of investigations – especially if their membership includes a wide representation of local people. Nevertheless, it was recognised that there are challenges in setting up and maintaining CRGs: for example, logistical problems as IPCC staff cover wide geographic areas; difficulties in recruiting appropriate members quickly enough, particularly when there are negative perceptions of the IPCC in a local community; and limitations on the kind of information that can be shared with CRGs in certain cases.

We recognise that in certain high profile or sensitive cases, CRGs can play an important role in helping to address community concerns and ensuring communities are confident that a full and thorough investigation will take place. **In September 2012 we introduced a new critical incident management process** for any incident where the effectiveness of the police or our response is likely to have a significant impact on the confidence of the family of someone who has died and/or the community. A multi-disciplinary team is set up, including the commissioner, lead investigator and other staff.

Central to the critical incident approach is recognising the fundamental importance of community confidence and trust in the police and in the IPCC. Views from the team will inform the commissioner's decision on how to approach community engagement, including whether a CRG, or other means of community engagement, should be set up or whether other community impact assessment work (including by the police) should be carried out.

It is not only the families of those who have died, but also the communities who are affected by a death, who need to trust us and our ability to get to the truth of what happened. Yet we know from our own research that there is a significant lack of trust in the IPCC among certain groups in the community, particularly those groups who also mistrust the police.

We have been developing a strategy to change the way we exercise oversight of the whole of the police complaints system and improve public confidence in it. We are now consulting on this strategy[35] and will be implementing it as an important part of our growth and change. This year we will be repeating our biennial public confidence survey. These initiatives will help us identify and communicate with groups and communities where there is particular lack of trust. **We will take positive action to increase our engagement with these communities, including following a death**.

Engaging with the public through the media

Media engagement is important to inform communities and the broader public about our investigations. It can also assist us in our investigation work, for example when we use the media to appeal for witnesses to an incident. However, a range of stakeholders who responded to the review identified concerns about how we engage with the public through the media. They included: how we ensure information is accurate before it is made public, how we ensure we strike the right balance in the amount and type of information we provide to the public, and how we use the media to increase understanding of our work.

We have recently clarified our approach to issuing press releases in independent investigations, in response to concern about the accuracy of information included in press releases, in particular in the early stages of an investigation. **Statements issued at the start of an investigation (when few details have been confirmed or tested) will be brief and limited to facts verified by the IPCC investigator**. As stated above, we will share advance copies of all press releases with the family and the force to ensure that they are factually accurate.

35. View the IPCC consultation website page: www.ipcc.gov.uk/page/consultations

Respondents to the review recognised that there is a difficult balance between providing too much or too little information to the media. Yet stakeholders from various sectors felt that we should engage more proactively with the media – in relation to specific investigations and more generally – in order to inform the general public about our role, remit, powers (and the limits to our powers), and investigation outcomes. This was considered essential for building public confidence.

Others, however, noted that limited resources and restrictions on information that can be publicly shared inevitably affect the quality of media engagement. Some IPCC commissioners who were interviewed as part of the review suggested that it was better to prioritise engagement with families, communities and stakeholders affected by individual cases.

Some stakeholders suggested that we could be more innovative in our approach to media engagement, for example by using social media. We agree that this provides an opportunity to expand the reach and responsiveness of our communication to the public within limited resources. As part of our communications strategy, **we are exploring making greater use of social media such as Twitter. This allows us to communicate directly with the public in dynamic and fast-moving cases and to clarify any misleading coverage quickly and robustly**.

We recognise that failure to communicate effectively about what we are doing (particularly in cases that are sensitive and high profile) can have a significant impact on public perception of an investigation and of the IPCC. However, striking the right balance, without compromising the integrity of the investigation, will continue to be a challenge.

As we grow and develop, we will review all of our communications strategy, to help us ensure that we can communicate our work, role and outcomes more effectively.

7

Reports, outcomes and learning

This chapter looks at evidence gathered during the review and our response in relation to the final stages of an IPCC investigation into a death and what can or needs to happen as a result.

7.1 Investigation reports

This section deals with:

- quality and accessibility of investigation reports
- sharing draft reports with interested parties
- disclosure and publication of reports

Background

At the conclusion of an independent investigation, a final report is produced that describes and analyses the evidence collected during the investigation, and the conclusions drawn from this.

The report can include recommendations for individual forces, or for policing nationally. It also states our conclusions on whether there are any conduct or performance issues for individual officers or staff and how they should be addressed. If the investigation concludes that there are potentially criminal issues, the report is sent to the Crown Prosecution Service for a decision about prosecution.

We have committed to publishing on our website the reports of all independent investigations begun on or after 1 April 2012. We will usually publish the final report after any inquest, prosecution or disciplinary proceedings. Reports or certain information in the report (such as names of witnesses or details of covert operations) may be withheld, based on the 'harm test' (see p. 66).

Our response to the evidence from the review

Stakeholders – including police, families and voluntary organisations – raised concerns about the quality and accessibility of our reports. Similar concerns have also been raised by our own staff and commissioners.

IPCC response at a glance

Investigation reports

Principles:

➜ Our reports must be clear and accessible, address all the terms of reference and contain an analysis of the evidence gathered to support the conclusions reached.

Actions:

- We will implement a new report writing framework and guidance designed to focus investigation reports on the key themes and questions to be answered under the terms of reference. There will be a specific framework for Article 2 investigations. All investigators will receive guidance and training to support them in using the framework.
- As part of our change programme, we will consider creating an enhanced editorial function to ensure our reports are clearly written.
- A multi-disciplinary approach, involving commissioners, lawyers and the lead investigator, will ensure that there is effective analysis of the evidence to support robust conclusions.
- We will highlight any areas where we have been unable to gather or test evidence (including non-cooperation from witnesses and issues/failures that relate to other agencies outside our remit) so that these can be tested in further proceedings, such as inquests.

Discussion of the evidence and our response

Quality and accessibility of investigation reports

A number of stakeholders from all sectors, including IPCC staff and commissioners, raised concerns about the quality and accessibility of some of our investigation reports. Stakeholders pointed to instances of reports lacking detail or including factual inaccuracies and contradictions; failures to show sufficient analysis of the evidence, and conclusions that are not strong enough, or do not appear to be supported by the evidence.

"Failure to test evidence or resolve conflicts and gaps in evidence is common to many reports. Such gaps/conflicts should be acknowledged rather than left unexplained. Some significant issues, e.g. restraint, are largely glossed over in reports, rather than subject to evidential analysis."

INQUEST

Some respondents said that the content of reports should be made more accessible by using less jargon and technical language, and clearer and more consistent formats. Concerns were raised, including by IPCC staff, about the use of police language in reports (such as terms like 'assailant' or 'male' rather than 'man') and the impact this has on perceptions of independence.

In early 2013, we set up a working group to improve the quality of our investigation reports, recognising that they have not always been of a consistently high quality. This has led to the development of **a revised report writing framework and guidance**.

The framework will provide a standard approach to writing reports: covering the introductory and background information, the relevant law, investigation methodology, the discussion and analysis of evidence, the investigation conclusions and recommendations. The evidence, including a full timeline and the complete text of any expert reports will be attached as appendices. As part of the multi-disciplinary approach we have set out previously in this report, there will be ongoing analysis and testing of investigation findings, creating the groundwork for the final report.

Previously our reports have usually set out the evidence as a chronology of events. **The new framework provides a more flexible issue-based format** where the evidence and analysis is considered in the light of the questions raised in the agreed terms of reference, or key themes that emerged from the investigation. The framework for **Article 2 investigations will show how the specific requirements of Article 2 have been met, including how the family's concerns or questions have been addressed**.

All investigation reports will include a foreword by the commissioner, summarising the key issues in the investigation, setting out the context of the investigation and commenting on the findings and the police response.

The framework will be supported by guidance to staff, making clear that:

- we will not use police language and terminology unless we are quoting the police, or it is otherwise necessary to do so
- we will set out the role of other organisations, and outline how any investigations being undertaken by other bodies relate to our investigation
- we will set out any issues that may have arisen in securing evidence, including details of anyone the investigation team would have liked to interview but were not able to, and anyone who refused to answer interview questions verbally or gave no comment interviews
- we will highlight for the coroner any areas that we consider need to be further addressed at the inquest. If we consider that a criminal offence may have been committed, we will set out which offences should be considered by the Crown Prosecution Service (CPS), giving our reasons

This new approach will be implemented in 2014, and all investigators will receive guidance and training in using the framework. As part of our change programme we will create an enhanced editorial function to ensure our reports are clearly written.

Sharing our investigation reports

Stakeholders welcomed our commitment to publish reports and recognised that some information may need to be removed or 'redacted' before the report is released. However, families and some police respondents were frustrated if this led to delays in issuing reports.

"If you have no information, you start working on the very little information that you have, and that might be wrong, so... you might think they are looking at very, very serious offences, when in fact they might not be. And that impacts again on your family, on your work life."

Police Officer – NatCen interview

If an inquest and/or criminal or disciplinary proceedings take place after the investigation, we have to consider whether the disclosure of the final report could undermine those proceedings. We will consult with the Crown Prosecution Service, the appropriate authority[36] and the coroner, as required, before disclosing the report (including draft reports) to the family and any other interested parties.

36. The appropriate authority is usually the chief officer of the police force involved.

In some cases, we will only be able to publish our reports or disclose them to the family with particular information redacted. This can be a time consuming process. **To avoid unnecessary delays, the revised guidance on writing reports will make clear that reports should, wherever possible, be written in a way that reduces the need for significant redaction** (but without compromising the integrity of the information). We will only redact information where absolutely necessary and we will give a clear explanation of why the redaction is necessary.

We will continue to publish investigation reports online, usually after any proceedings have been completed. Reports will include a search function as well as hyperlinks to other documents and reports and, where possible, links to videos, CCTV stills and graphics which form part of the report. **We will consider creating alternative accessible formats or an easy-read version of a report where there is a need to do so**.

Families and the organisations that support them strongly argued that they should be given the opportunity to see a draft of the investigation report before it is finalised so that they can see how the terms of reference have been met, and that there are no factual inaccuracies. This is addressed in chapter 6, *Engagement during investigations*.

7.2 Outcomes

This section deals with the evidence gathered and the IPCC response in relation to:

- our role and powers in criminal proceedings
- our role and powers in disciplinary proceedings
- working with coroners when there is an inquest

Background

Other statutory processes, such as criminal prosecutions and inquests, play a part in fulfilling the state's obligation under Article 2 to ensure that an official, effective investigation is undertaken into any death that may involve an Article 2 breach. We need to work closely in our investigations with the other statutory bodies involved in fulfilling this obligation, such as the Crown Prosecution Service (where there may be criminal prosecutions), the coroner and where appropriate, the Health and Safety Executive.

At the end of an independent investigation we must decide whether there is a case to answer for misconduct or poor performance for any officers or staff. If we find there is a case to answer for misconduct, we can recommend or direct that disciplinary proceedings take place.

The police force is responsible for disciplinary proceedings. We cannot decide the outcome of these proceedings or the sanction for the officer or staff member.

If we think a police officer or member of police staff may have committed a criminal offence, we will refer the case to the Crown Prosecution Service (CPS). The CPS is then responsible for deciding whether the person should be prosecuted.

In relation to inquests, we work with coroners both during and after an investigation.

Our response to the evidence from the review

It is important that our investigations are seen to make a difference. We must be able to show that, where necessary, the police have been properly held to account. Our investigations and investigation reports need to be sufficiently robust to support subsequent proceedings and inquests. The steps that we are taking to strengthen our investigations are outlined in the previous chapters in this report.

IPCC response at a glance

Outcomes

Principles:

- ➜ Our investigations must lead to strong and defensible outcomes that we can demonstrate.
- ➜ Internal police disciplinary systems must be sufficiently robust to command public confidence.

Actions:

- We will publish the outcomes of our investigations, clarifying our own outcomes and those that result from disciplinary or criminal processes.
- We have responded to the Home Office consultation[37] on improving the police disciplinary system and making it more transparent and will continue to make the case for reform.

37. View our response online: www.ipcc.gov.uk/sites/default/files/Documents/news/IPCC_response_to_Home_Office_consultation_on_proposals_for_improving_the_police_disciplinary_system_August_2013.pdf

Discussion of evidence and our response

Explaining our role in criminal and disciplinary proceedings

Stakeholders suggested that the limit of our role and powers in relation to criminal and disciplinary proceedings was often misunderstood. We need to do more to clarify this. **We will publish the outcomes of our investigations, and of any subsequent criminal or disciplinary proceedings, so that the public are aware of the results of our work and of any proceedings that follow**.

Criminal proceedings and working with the CPS

Stakeholders raised some concerns about how we refer cases to the CPS for charging decisions. Specifically, some said that we did not offer an opinion to the CPS about the strength of potential cases against officers. Conversely, some officers said that the IPCC unduly influences decisions made by the CPS.

We have a memorandum of understanding[38] with the special crime division in the CPS, which is published on our website. Both the IPCC and CPS are independent organisations and each takes independent decisions as part of an investigation into a death. However, the agreement recognises that we need to engage with each other in order to provide an effective public service.

At the referral stage we inform the CPS of the mode of investigation decisions on all deaths, excluding road traffic incidents, within 24 hours. **This requirement has been reinforced in guidance to the new referrals team**. This early notification means that we can communicate in the initial stages of an investigation to clarify whether advice may be needed or the CPS may wish to be more involved. We regularly communicate during an investigation so that the CPS is aware of progress and the potential completion date of the investigation. This interaction provides an opportunity for us to take advice and guidance on lines of enquiry, the nature of charges and legal and evidential issues in a case before formal submission to the CPS.

We also meet CPS senior staff on a quarterly basis to monitor the progress of cases that have been referred to them, dealing with issues arising and identifying learning for both organisations.

Once a case is referred to the CPS, the decision on prosecution is solely taken by the CPS. We will keep the family updated about our engagement with the CPS, but the CPS are responsible for explaining to the family their decision about whether they will prosecute. We make it clear in press releases that decisions have been taken by the CPS rather than ourselves, and we will continue to emphasise this. We also carry out joint debriefs with the CPS following prosecution.

38. View the memorandum of understanding online: www.ipcc.gov.uk/Documents/guidelines_reports/MoU_Working_arrangements_between_the_IPCC_and_CPS_Special_Crime_Division.PDF

We will continue to work with the CPS to ensure we work more effectively to minimise delays. We will consider whether the memorandum of understanding between the two organisations needs revising to reflect any new practice.

The police discipline process

We have expressed serious concerns about the transparency, independence and timeliness of the current police disciplinary process. These concerns were shared by many of the respondents to the review – particularly voluntary and community sector respondents and families, but also some police forces.

A number of respondents gave examples of cases where police disciplinary procedures produced outcomes that did not match the findings of the IPCC investigation, and this was seen to undermine confidence in the system as a whole. To address this, some stakeholders suggested that the IPCC should have powers in relation to the disciplinary process, including powers to make disciplinary decisions, to present cases at hearings or to direct that officers be suspended.

"The view of West Midlands Police is that it's a strange process for the IPCC to carry out an investigation and then not be the decision maker on the action required. It would make more sense if the IPCC were the decision makers following an independent investigation and this would illustrate independence to the public."

West Midlands Police

Others thought that while new powers are not necessarily required, we should make greater and more robust use of our existing powers to direct disciplinary proceedings.

We share the frustration when there is a clear disconnect between our investigation findings and the outcome of the misconduct hearing that follows. In some instances, although we have determined that an individual has a case to answer for gross misconduct, the panel at the subsequent misconduct hearing concludes that the individual's conduct amounts to misconduct only, or that it amounts to no misconduct at all.

In other instances, the panel agrees that the individual's behaviour amounts to gross misconduct but then goes on to impose a sanction that is more lenient than the IPCC and families would expect and which, in our view, does not reflect the seriousness of the failings identified.

Dismissal is the most severe sanction that can be imposed at a hearing if a panel finds that an individual's behaviour amounts to gross misconduct. If the force does not accept our findings and we have used, or threatened to use, our power to direct a hearing, it is noticeable that dismissal has never followed.

At present, apart from proceedings for chief officers, the disciplinary system remains a largely internal process carried out in private within forces. If public confidence is undermined when the police investigate themselves, it is surely also undermined if they discipline themselves – particularly if appropriate action is not seen to be taken against individuals found to be at fault.

In our view, the current disciplinary process is in urgent need of reform and we have expressed this view in our published response to the recent Home Office consultation[39] **and in the working group currently considering change.**

We do not consider that the IPCC, as the investigating body, should also be the decision-maker on disciplinary sanctions. However, we believe that there is an urgent need to introduce independence and transparency into the disciplinary system – as is the case for other professions in the 21st century.

We will continue to make the case for reform of the police disciplinary system, so that it becomes more timely, transparent and independent of the police service, and the public can be more confident that individual officers and staff will be held to account when things go wrong.

Working with coroners

A small number of stakeholders noted issues around the way we engage with coroners during and after investigations and our role at inquests. It was suggested that both investigations and subsequent inquests would benefit from earlier and more proactive contact between the IPCC and coroners, and from greater clarity concerning our respective roles, standards and expectations.

The often lengthy delays in the holding of inquests are a major cause for concern. They not only add to families' distress, and delay an appropriate resolution for forces and police officers, but they can also undermine public confidence in our investigations. Concerns were raised that this is sometimes caused by delays on our side in disclosing information to the coroner, or poor communication more generally. Some also said that if our investigations could resolve the contentious features of cases, this would result in shorter and less complicated inquest hearings.

When a death has occurred, the coroner will open and adjourn the inquest until after our report is completed. During the investigation, the lead investigator may have attended pre-inquest hearings to provide information about the progress of the investigation and to deal with legal issues such as disclosure. At the end of the investigation we provide the coroner with a copy of the report and the underlying evidence, and continue to liaise with them after the investigation has finished.

39. View the IPCC response online: www.ipcc.gov.uk/sites/default/files/Documents/news/IPCC_response_to_Home_Office_consultation_on_proposals_for_improving_the_police_disciplinary_system_August_2013.pdf

We need to ensure that we can disclose evidence and information to the coroner in a timely and efficient way. This has a significant impact on resources and we know that on occasions we have not been able to do this well enough. **In our new operating model, we will develop a specialist investigations support function, including staff who specifically liaise with coroners (and other relevant bodies) to ensure full and timely disclosure**.

We are meeting the chief coroner and his staff, to discuss our interaction with coroners and how we can ensure that we share issues and learning from our investigations and from coroners' reports to prevent future deaths. **We will continue to develop our relationship with the chief coroner by holding regular meetings to ensure effective interaction and communication. We will also consider whether our memorandum of understanding with the Coroners' Society needs revising to reflect recent developments in legislation and the findings of this review and to clarify our role in inquests.**

7.3 Learning and improving police practice

This section deals with the evidence gathered and our response in relation to:

- making and following up recommendations
- working to improve police practice to prevent future deaths

Background

We make recommendations about actions that we consider the police force should take to prevent the repetition of serious incidents. We also note lessons for police procedures and practices more generally. We publish a regular bulletin to help the police service learn lessons. Sometimes we publish more general thematic reports, which have led to improvements in the police's own guidance – for example, on safer detention, road traffic pursuits and, most recently, dealing safely with those who are drunk and incapable.

Our response to evidence from the review

It is important that our investigations make a difference, so that learning from our work leads to changes in police practice and appropriate action is taken by forces to prevent future deaths.

IPCC response at a glance

Learning and improving police practice

Principles:

➜ Learning from investigations must inform better policing practice.

Actions:

- Chief officers will be required to respond formally to our recommendations when the Anti-Social Behaviour, Crime and Policing Bill becomes law. We will put systems in place to ensure that we make best use of this new power and will liaise with police and crime commissioners to ensure that they are aware of our recommendations and the chief officer's response.
- As part of our change programme, we will develop systems and support and train staff to ensure that recommendations are consistent and informed by best practice and related recommendations made by us or others. This will be supported by improved knowledge management systems.
- We are developing an agreement with Her Majesty's Inspectorate of Constabulary and the College of Policing to ensure effective links between our recommendations and standard-setting and inspection.
- We will carry out thematic work: in 2014/15 on use of force, including the use of restraint and lethal force by the police.

Discussion of the evidence and our response

Making and following up on recommendations

A widespread view – among voluntary, community and statutory stakeholders, IPCC staff and some police consultees – was that there should be a requirement for forces to respond formally to our recommendations, and to provide an explanation for why any recommendations have not been acted on. Stakeholders also argued for us to exercise much more proactive monitoring of police responses to recommendations, including visiting forces to review implementation and challenging those that have not taken action. It was also suggested that force responses to recommendations should be published, or that we should annually publish our recommendations and how they have been responded to.

"We support a system where recommendations made by the IPCC are routinely recorded and formally responded to with an action plan from the police. Where a recommendation is not followed by a force, we would like the force to explain its reasoning."

Police Foundation

Some stakeholders – mostly voluntary and community groups and IPCC staff – thought that our recommendations should be made binding on police forces.

"The IPCC should have powers to enforce recommendations within the force area where weaknesses have been found, but also in other police forces areas where similar weaknesses exist. Without this we will continue to see the same errors repeated at the cost of victims' lives."

Suzy Lamplugh Trust

However, a number of police consultees and some statutory organisations cautioned against taking this approach, on the grounds that it would limit chief officers' ability to direct their forces and restrict forces' flexibility.

"The introduction of binding recommendations would remove the flexibility for forces to implement reviews and changes in the way that best suits their area."

Welsh Government Minister for Local Government and Communities

We believe that police forces should be required to respond to our recommendations and we have sought a change in the law to ensure that this is the case. **The Anti-Social Behaviour, Crime and Policing Bill, which is currently going through Parliament, will create a statutory framework for response to our recommendations**. The recipient of a recommendation (usually the chief officer) will have to respond within 56 days, and this response will be published. We expect this to come into effect in late 2014. **We will put into place processes to ensure that we make best use of this new power**.

We will liaise with police and crime commissioners to ensure that they are aware of our recommendations and the chief officer's response. If we consider that insufficient action has been taken in response to our recommendations, we will report this to police and crime commissioners and make our views known to ministers and the public. We do not believe that we should have powers to enforce recommendations or inspect against them. Organisations that have tried to mix regulation and investigation have run into great difficulty. If an organisation is responsible for setting and enforcing standards, it is hard, if not impossible, to be objective about whether those standards are adequate. It is also not clear whether the organisation is acting in a regulatory or an investigative capacity. It is also important to protect the distinctive role of inspection, which needs to be proactive and preventive, from the reactive and demand-led process of investigation.

However, we do need to work closely with those bodies that have the responsibility for standard-setting and inspection, to help ensure that our recommendations lead to real change across the police. This is discussed in the section below.

There were also comments on the quality and strength of our recommendations, with stakeholders from police and voluntary and community sectors suggesting that we should develop a greater awareness of best practice and reflect this in our recommendations. Several stakeholders – including voluntary/community and statutory organisations – suggested that the scope of learning should be broadened, so that cross-cutting and recurring themes emerging from individual investigations are identified, and forces can make broader cultural, organisational and policy changes. It was also suggested that we could strengthen our reports and recommendations by putting them in the context of our own policy and research work and previous investigations as well as recommendations made by coroners and others.

We will develop knowledge management systems and staff training to ensure that recommendations are consistent and informed by an understanding of best practice and previous recommendations made by us or others.

As part of our change programme, we are increasing our policy and analytical capacity and improving knowledge management systems. This will make us better able to identify emerging trends from our investigations and complaints work.

Working to improve policing practice to prevent future deaths

Police and some statutory stakeholders said that our Learning the Lessons bulletins and thematic reports are valuable, and have improved police practice.

"Examples of the IPCC making recommendations which have led to improvements in guidance and practice include improvements to policing practices and safer transportation and handling of detainees; improving standards of care for those in custody; addressing public safety issues arising from police pursuits; and better informed assessments of vulnerability, risk, threat and harm."

ACPO Professional Standards

It was strongly argued that we should give a higher priority to developing and sharing good practice and other learning on how to prevent deaths and other serious incidents during or following police contact. There were also concerns that lessons learnt, including in terms of good practice, are not widely enough disseminated, and that the same issues arise over and over again.

"The fear is that shocking, contentious cases generate an immediate response and learning but that is not embedded and the same patterns repeat themselves. For example, INQUEST is deeply concerned by the recent high numbers of deaths involving mental health and restraint, including the use of prone restraint, which are reminiscent of cases from ten years ago."

INQUEST

A range of stakeholders (voluntary and community, police and statutory) suggested that there should be greater liaison with Her Majesty's Inspectorate of Constabulary (HMIC) and the joint police custody inspections that are carried out by them and the prisons inspectorate (HMIP). One suggestion, for example, was that IPCC investigation reports could feed into the planning process for inspections carried out by HMIC. Respondents also noted the need for liaison with the College of Policing, police and crime commissioners, the Association of Chief Police Officers and other relevant bodies.

"Working with all relevant enforcing authorities in each case would help to ensure that all lessons from investigations are identified and used to inform future practice in forces. Such learning could inform HMIC's interventions with forces."

Health and Safety Executive

We agree that we need to strengthen our work with other bodies to establish a virtuous circle, so that the issues that arise in our investigations feed into the standards set by the College of Policing and the inspections carried out by HMIC.

We are in discussion with these bodies and **are developing arrangements that clarify our respective roles and enable better liaison and cooperation between us**. We already have a process in place to feed the findings and learning from our investigations into the joint police custody inspections undertaken by Her Majesty's Inspectorate of Prisons (HMIP) and Constabulary (HMIC) and we are also revising our memorandum of understanding with that inspection team, to reinforce these arrangements for information sharing. We anticipate a similar process to ensure that our work informs the regular force inspections that HMIC will now be undertaking, as well as their thematic inspections.

We have had positive feedback on our thematic reports. We will build on this area of work in our proposed oversight and confidence work.[40] **Next year we will be carrying out thematic work on the use of force, including the use of restraint and lethal force by police**. The proposal for the research is available on our website.[41]

40. For more details about our oversight and confidence work, visit the IPCC website: www.ipcc.gov.uk/page/consultations

41. View the proposal on the IPCC website: www.ipcc.gov.uk/sites/default/files/Documents/research_stats/IPCC_use_of_force_research_study_2013.pdf

8 Conclusion and next steps

This review has provided invaluable feedback about the way we investigate cases where there has been a death. It is already making a significant difference to our work, not just in these investigations, but across all our activity.

We have begun to receive some encouraging feedback that this is starting to have an impact on those involved in our investigations, though we recognise that there is still more we need to do.

"During this year the IPCC decided to re-investigate the death of my son in police custody. We feel that the new investigation is more robust and thorough than the first and in particular, we have been regularly updated. We were consulted carefully regarding the terms of reference and we have met the Commissioner on several occasions. Real progress has been made and I am pleased to be able to acknowledge that."

Family member – Next steps event

Since we started the review, the Home Secretary has announced that she proposes to transfer resources to the IPCC to enable us to carry out more independent investigations. This will enable us to implement many of the changes that have been suggested in feedback to this review. We are not just planning to take on more work in the same way, but to use this as an opportunity to re-shape the way we carry out our work and to reinforce our independence and values. This will be a challenging time for us, and we want to continue working with those most affected by our work.

Next steps

Throughout the report we highlight the principles that we are now working to and the actions we are taking or are planning to take in response to the review. A plan of all the actions outlined in the report is included at Annex C. We will be implementing this alongside the action plan in response to the recommendations for Dr Casale's review into our investigation into the death of Sean Rigg. This plan and our initial progress against the actions are available on our website.[42]

We will be tracking progress against both action plans and this will be monitored by the Commission. We will also go back to the external reference group for this review and to Dr Casale at a face-to-face meeting after six months to provide an update on the progress we have made, and to get further feedback. We will publish a report on our progress against the action plan following this meeting.

42. View the plan and updates on actions on the IPCC website: www.ipcc.gov.uk/investigations/sean-rigg-metropolitan-police-service

We want to continue the dialogue with those affected by, or with an interest in, our work, so that we can continue to develop and improve the service we provide. As set out in this report, we will be seeking ways to improve and learn from the feedback from families and others directly involved in our investigations.

Once again we would like to thank everyone who participated in the review. Your contributions are helping us to mould the new IPCC, as it takes shape over the next three years.

Annex A:

IPCC investigations and Article 2 of the European Convention on Human Rights

Article 2 of the European Convention on Human Rights provides that everyone's right to life should be protected by law. It places an obligation on the state not to take life, except in very limited and defined circumstances, and to take reasonable steps to protect life where there is a real and immediate risk.

Deaths that occur during or following police contact may involve a breach of Article 2 by the police. Cases where there may be such a breach are those where:

- a death has been caused by police use of force;
- an individual has died while in police custody or under arrest;
- a death has resulted from a third party's criminal use of force, where the police failed adequately to investigate the third party's actions where they knew or ought to have known there was a real and immediate risk to life; or
- there has been a fatal road traffic accident involving the police.

Under Article 2, the state has to ensure that an official, effective investigation is undertaken into any death that may involve an Article 2 breach. Any case involving a death where there is an indication that the police may have breached Article 2 should initially be investigated independently by the IPCC. In conducting such investigations, we are contributing to the UK's fulfilment of its Article 2 obligation to investigate. Other statutory processes, such as criminal prosecutions and inquests, also play a part in fulfilling this obligation.

As part of this review, we have assessed and clarified our obligation to investigate under Article 2, as outlined in Item 1.

Item 1: IPCC obligation under Article 2 to conduct independent investigations into cases involving a death

a) The IPCC has an obligation to begin an independent investigation into all cases which engage Article 2: that is, all cases in which there may have been a breach of Article 2 by the police.

b) All deaths that occur in police custody potentially involve a breach of Article 2 and should therefore initially be investigated independently by the IPCC.

c) Some deaths that occur following police contact potentially involve a breach of Article 2 and should therefore also initially be investigated independently.

d) In other cases of death following police contact, it may be clear from the outset that there was no breach of Article 2 (for example, where an individual has died of natural causes some time after contact with the police), and therefore the IPCC can decide on an alternative to independent investigation.

e) If it becomes clear, during the early stages of an independent investigation by the IPCC, that a death during or following police contact did not involve a breach of Article 2, the mode of investigation can be re-assigned to managed, supervised or local.

Article 2 investigations should be inquisitorial and draw conclusions beyond misconduct and criminal behaviour i.e. exploring poor practice or omissions in duty of care. They should consider what happened, why it happened, who (if anyone) is responsible and how a death could be prevented in the future.

There is no set structure for an investigation into a death that engages Article 2. However, such an investigation must have certain features, as outlined in Item 2.[43]

Item 2: Essential features of an Article 2 investigation

- **Independent**

The investigation must be independent, institutionally and in practice, and must be carried out on the state's instigation.

- **Subject to public scrutiny**

The findings of investigations should be published; and proceedings before tribunals should be held in public, as far as is reasonably possible.

- **Prompt**

The investigation should proceed with no unreasonable delays.

- **Effective**

The investigation should be thorough, wide-ranging and rigorous. It must be able to assign responsibility for the death and, if agents of the state are responsible, determine if the killing was justified under Article 2. The investigative organisation may need to make recommendations to prevent the recurrence of the circumstances that led to the death. The investigation should not only examine individuals immediately connected with the death, but also any planning and preparation matters and relevant policies employed by those immediately connected with the death.

- **Engaged with the next of kin**

The next of kin must be sufficiently involved to safeguard their legitimate interests. Information concerning the death should be disclosed, and they should have financial and legal assistance to enable them to participate in the process.

43. See also R v Secretary of State for the Home Department ex p Amin (2003) UKHL 51.

Annex B:
List of consultation activities and consultees

The IPCC has undertaken a broad range of consultation in relation to the review of its work in investigating deaths. We have sought views from bereaved families, their legal representatives, community and voluntary organisations, statutory bodies and the police.

Throughout the final report, the feedback received has been categorised according to five respondent groups:

- families
- voluntary/community groups (including lawyers representing families)
- statutory organisations (including government agencies and MPs)
- police (including organisations representing police officers and staff)
- IPCC staff and commissioners

Below is an outline of the consultation undertaken, with respondents grouped under these categories. We have published the submissions received and the notes from our consultation activities[44] alongside this report.

Written consultation

We held a written consultation for the review which closed on 11 January 2013. The consultation document[45] is available on our website.

Thirty one responses were received from external respondents and eight from IPCC staff. Responses were received from:

Voluntary and community groups

- INQUEST
- Mind
- Police Action Lawyers Group
- Suzy Lamplugh Trust
- The Police Foundation

Statutory organisations

- Equalities and Human Rights Commission
- Health and Safety Executive
- Her Majesty's Inspectorate of Prisons
- Independent Advisory Panel on Deaths in Custody
- Welsh minister for local government and communities

Police

- Association of Chief Police Officers (ACPO) Professional Standards
- Bedfordshire, Cambridgeshire and Hertfordshire Police Professional Standards Department
- Cheshire Constabulary
- Greater Manchester Police
- Leicestershire Police
- Lincolnshire Police
- Merseyside Police
- Norfolk and Suffolk Police Professional Standards Department
- North Yorkshire Police
- Northamptonshire Police
- Northumbria Police
- Nottinghamshire Police
- Police Federation

44. View the consultation responses and notes online: www.ipcc.gov.uk/page/review-ipccs-work-relation-cases-involving-death
45. View the consultation document online: www.ipcc.gov.uk/sites/default/files/Review%20of%20the%20IPCCs%20work%20in%20investigating%20deaths%20-%20Progress%20report.pdf

- Serious and Organised Crime Authority
- South Wales Police
- South West Regional Professional Standards Department
- Surrey Police Professional Standards Department
- West Mercia Police
- West Midlands Police

Other

- Individual member of the public
- Dr Nick Lynn, University of Portsmouth

IPCC Staff

Eight responses were received from IPCC staff members who were also invited to respond to the written consultation.

Stakeholder workshops

The IPCC held a series of three workshops with non-police stakeholders in London, Birmingham and Manchester in March 2013. The workshops were designed to facilitate group discussion around the areas outlined in the consultation document. Representatives from the following organisations were represented at the workshops:

Voluntary and community groups

- Birmingham & Solihull Women's Aid
- British Federation of Race Equality Councils
- Centre for Equality & Diversity
- Children's Rights Alliance for England
- Citizens Advice Bureau
- Co-ordinated Action Against Domestic Abuse
- Coventry Rape & Sexual Abuse Centre
- Eaves
- Harrison Bundey Solicitors
- Manchester People First
- Metropolitan Police Independent Advisory Group – Enfield
- Metropolitan Police Independent Advisory Group – Hillingdon
- National Stalking Clinic
- NIA
- NoOffence!
- Pakistan Association Huddersfield
- Police Foundation
- Race On The Agenda
- Regional Action West Midlands
- Safer London Foundation
- Safety Net Associates Group
- South Asian Consortium Kirklees
- Suzy Lamplugh Trust
- Women's Aid

Statutory organisations

- Chief Coroner's Office
- Crown Prosecution Service
- Equality and Human Rights Commission
- Faculty of Forensic and Legal Medicine of the Royal College of Physicians
- Brighton & Hove City Council
- Health & Safety Executive
- Ministry of Justice
- West Midlands Fire Service

A number of academics and other individuals with an interest in the IPCC's work also attended.

Stakeholder interviews

The IPCC undertook a series of individual interviews with key stakeholders focusing on elements of the consultation document relevant to them. Representatives from the following stakeholders were interviewed:

Voluntary and community groups

- Black Mental Health UK
- Centre for Mental Health
- Independent Custody Visitors Association
- Ms Shahda Khan MBE

Statutory organisations (including members of parliament)

- Crown Prosecution Service
- G4S
- Her Majesty's Inspectorate of Constabulary
- Her Majesty's Inspectorate of Prisons
- Independent Advisory Panel on Deaths in Custody
- Tom Brake MP
- David Lammy MP
- HM Coroner Mr Tweedle

Group seminars/Listening days

Families

The IPCC co-hosted a listening day with the charity INQUEST for bereaved families who had experience of an IPCC investigation into a death. The event took place over two days (13th and 14th March 2013) and involved 26 family members representing 14 families. Additional written submissions were made by a further three families unable to attend in person.

Voluntary and community groups

- **Black Mental Health UK**

The IPCC co-hosted a community engagement seminar with Black Mental Health UK. Attendees were a mix of community and church leaders, students, professionals from different backgrounds as well as mental health service users from African Caribbean communities and staff from related support agencies.

- **British Transport Police Youth Board**

The IPCC hosted an engagement seminar with four members of the British Transport Police Youth Board.

- **Lawyers representing bereaved relatives**

The IPCC also held a group discussion with lawyers from the Police Action Lawyers Group and INQUEST lawyers group.

National Centre of Social Research

As part of the review, the IPCC commissioned National Centre of Social Research (NatCen), an independent research institute, to undertake research into the views and experiences of bereaved families, IPCC staff and commissioners, police officers and others.

NatCen undertook the following consultation:

Families

- Three in-depth interviews with family members (involving four family members)

Non-police stakeholders (covering voluntary/community and statutory groups)

- Four in-depth interviews with non-police stakeholder organisations
- Four focus groups/interviews with Community Reference Group members

Police

- Four in-depth interviews with police officers
- One in-depth interview with a police federation representative

IPCC staff and commissioners

- Eight in-depth interviews with IPCC commissioners
- Five focus groups with IPCC staff

Progress report consultation event

In October 2013 we invited all those who had contributed to the review to an event, which provided an opportunity to discuss the actions outlined in the progress report[46] and to get further feedback on the approach we were taking.

46. View the progress report online: http://www.ipcc.gov.uk/sites/default/files/Review%20of%20the%20IPCCs%20work%20in%20investigating%20deaths%20-%20Progress%20report.pdf

Representatives from the following organisations and groups attended the event:

Families

The event was attended by a number of family members who had engaged with the review through the INQUEST family listening days or through NatCen interviews.

Community and voluntary groups

- Advocacy After Fatal Domestic Abuse
- African Caribbean Community Initiative
- Black Mental Health UK
- Citizens Advice Bureau, London
- Family Health Isis
- I & I services
- InPDUM London
- INQUEST
- Liberty
- Maat Probe
- Metropolitan Police Independent Advisory Group – Hillingdon
- New Testament Church of God
- No Offence!
- Pakistan Association Huddersfield
- Police Action Lawyers Group
- Public and Commercial Services (PCS)
- South Asian Consortium Kirklees
- Suzy Lamplugh Trust
- The Police Foundation
- Uhuru Movement – African Socialist International
- Unison black members
- Women's Aid

Statutory groups

- Care Quality Commission
- Crown Prosecution Service
- Equality and Human Rights Commission
- Faculty of Forensic and Legal Medicine, Royal College of Physicians
- G4S
- Health and Safety Executive
- Her Majesty's Inspectorate of Constabulary
- Her Majesty's Inspectorate of Prisons
- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Trust

Police

- Avon & Somerset Constabulary
- Bedfordshire and Hertfordshire Professional Standards Department
- Cheshire Constabulary
- Gloucestershire Constabulary
- Leicestershire Police
- Nottinghamshire Professional Standards Department
- Public and Commercial Services Union (representing police staff)
- Surrey Professional Standards Department
- West Mercia Police
- West Midlands Professional Standards Department

Other evidence

Beyond the consultation outlined above, we also considered other feedback we have received that relates to our work in cases involving a death. Significantly, this includes Dr Silvia Casale's independent review of the IPCC's investigation into the death of Sean Rigg.[47]

47. View the review online: www.ipcc.gov.uk/sites/default/files/Documents/investigation_commissioner_reports/Review_Report_Sean_Rigg.PDF

Annex C: Action plan

Ref	ACTIONS	OWNER	TIMETABLE
	Independence		
1	We are revising our conflict of interest policy for all staff and commissioners, and are strengthening the initial training on conflicts of interest that is provided to all staff.	Amanda Kelly	Jul -14
2	As we expand, we will ensure that there are specific restrictions on investigators leading an investigation into a force where they have previously worked.	Moir Stewart	Dec -14
3	We are already planning to expand our training programme for all staff, to include training on identifying and challenging personal bias.	Colin Woodward	Mar -15
	Scope and remit		
4	We will consider any relevant interaction between the police and other agencies in our investigations into deaths. If the actions of other organisations are relevant, but beyond our own remit, we will inform the coroner and other agencies or oversight bodies where appropriate.	Moir Stewart	In place
5	We have asked for additional powers in relation to private sector contractors carrying out policing functions, to ensure that we are able to investigate complaints and conduct matters associated with them. These powers are included in the Anti-Social Behaviour, Crime and Policing Bill, which is currently before Parliament.	Sadie East	Oct- 14
	Initial steps in assessment and investigation		
	Referral and mode of investigation decision-making		
6	Chief Constables have been reminded of their duty to refer deaths immediately. We will address any delays in referral as part of our investigation and final report. We will consider whether this raises issues of misconduct.	Moir Stewart	In place
7	We have set up a dedicated team to deal with referrals to address concerns about consistency, timeliness and transparency of decision making. We will use the learning and experience from this work to develop a dedicated assessment function as part of our new organisational structure.	Moir Stewart	Jul -14
8	We will publish the criteria that we consider when we make a decision about how a case should be investigated.	Moir Stewart	Sep -14
9	Decisions about whether to investigate independently will include consideration of whether discrimination (for example because of race, mental health, gender, disability, sexual orientation) may be a relevant factor in the death.	Moir Stewart	In place
10	With more resources, we will be able to do more independent investigations, for example where a death has been narrowly avoided.	Moir Stewart	Mar -15

Ref	ACTIONS	OWNER	TIMETABLE
	Post-incident management		
11	We have developed draft statutory guidance under Section 22 of the Police Reform Act in relation to achieving best evidence in death and serious injury investigations. This sets out our expectations of the actions the police should take to identify all potentially relevant evidence and preserve the integrity of that evidence. The draft guidance also specifies that key policing witnesses should be separated before providing their initial accounts and should not confer.	Moir Stewart	Consultation starts in Mar -14
12	Investigators have received further training and guidance on scene management to ensure that they have the skills and confidence to take control of a scene, both remotely and on arrival, and to give and record guidance to police and contracted forensic providers.	Moir Stewart	Complete
13	Additional resources will allow us to open more offices and increase our geographic coverage.	Kevin Woodrow	Dec -14
14	As part of our change programme and our work on the development of a new operational model, we will review our on-call system, and consider how best to obtain specialised scene of crime expertise.	Megan Smart	Apr -15
15	We will explore with the Association of Chief Police Officers (ACPO) the feasibility of filming the process of scene preservation to ensure that evidence is secured and public confidence is maintained.	Moir Stewart	Oct -14
	Conducting the investigation		
16	We will develop the standard use of investigations plans in our investigation.	Moir Stewart	Apr -14
17	Staff have received additional training on the threshold for making decisions on criminality or misconduct, and on other matters relating to the use of our powers.	Moir Stewart	Complete
18	We delivered additional training for investigators in carrying out probing interviews, focusing on the lessons learned from Dr Casale's review. We also now transcribe all significant police witness interviews.	Moir Stewart	Complete
19	We have expanded the use of multi-disciplinary working, and issued new guidance on the role of the commissioner, to ensure robust internal challenge and analysis of evidence.	Moir Stewart	In place
20	We have proposed to the College of Policing that cooperating fully with investigations should be part of the proposed code of ethics for police officers and staff.	Sadie East	Complete
21	We are using our power to require officers to attend witness interviews as soon as possible after the incident. If we do not get effective cooperation, we will initially raise this with forces, and will consider whether further action or powers are needed.	Moir Stewart	In place

Ref	ACTIONS	OWNER	TIMETABLE
22	We will exercise powers under the Anti-Social Behaviour, Crime and Policing Bill, when it becomes law, to obtain information from non-police individuals and organisations.	Moir Stewart	Oct -14
23	We will revise our guidance to police on dealing with discrimination allegations.	Sadie East	March -15
24	Ensure that terms of reference actively consider discrimination issues.	Moir Stewart	In place
25	We are providing ongoing training to our staff on dealing with issues of discrimination.	Moir Stewart	In place
26	We will reflect the actions and principles in this report and Dr Casale's review in our new operational model. The new model will make our structures and processes more flexible and support timeliness and quality assurance. This will include external review.	Megan Smart	Dec -14
27	Once the new operational model is in place we will publish a revised operations manual so that our practices can be understood and scrutinised.	Moir Stewart	Apr -17
28	As part of our new operating model, we will ensure that we effectively use specialist expertise, both internally and through external support in areas such as forensics, mental health and discrimination.	Megan Smart	Apr -15
29	As we gain more resources, we will have more investigators, greater flexibility and expertise. We will create a specialist assessment function, and a single operational directorate.	Megan Smart	Dec -14
30	We will monitor and report on the impact of our power to compel officers to attend witness interviews, including any refusal to answer questions at interview rather than later in writing. We will raise this with chief officers and police and crime commissioners, and refer to it in our reports and public statements.	Moir Stewart	In place
31	We will review our guidance for investigators on pre-interview disclosure to ensure it reflects the findings of this review and supports the collection of best evidence.	Moir Stewart/ Sadie East	Apr -15
32	We are taking steps to increase our own knowledge and awareness about current mental health issues, and will review staff training in mental health awareness, incorporating service user experiences.	Moir Stewart	In place

Ref	ACTIONS	OWNER	TIMETABLE
Engagement during investigations			
	Engaging with families		
33	We are providing training on bereavement awareness and the stages of grief to all investigators and commissioners. Performance reviews for investigations staff will include assessments of their work with families.	Moir Stewart	May -14
34	As part of expansion, we will develop a new model for family liaison, drawing on the feedback from this review. This will be informed by a victim support approach.	Megan Smart	Apr -15
35	We have revised the initial information we provide to families and the letters they receive. We are developing a more detailed information pack to supplement this.	Sadie East	Sep -14
36	All families will have the opportunity to meet IPCC staff and commissioners at the beginning and throughout the investigation. They can ask questions and voice any concerns about the investigation's progress or approach.	Moir Stewart	In place
37	We will involve families in developing the terms of reference for the investigation so that they include the questions that the family wants us to try to answer.	Moir Stewart	In place
38	All press statements will be agreed, wherever possible, with families.	Charlotte Phillips	In place
39	We keep families updated on the progress of the investigation, disclosing all information, subject only to the 'harm test'.	Moir Stewart	In place
40	As we develop investigation plans, we will share them with the family. We will also explore providing them with draft reports.	Moir Stewart	Apr -14
41	We are carrying out a review of all our methods for seeking feedback. This will include how we seek regular feedback from families and their representatives to improve our work with families.	Kathie Cashell	Aug -14
	Engaging with the police force, police officers and staff		
42	We will share advance copies of press releases with the press office of the police force involved in our investigation , wherever possible, to ensure factual accuracy.	Charlotte Phillips	In place
43	As part of the review of our operations manual for investigations we will ensure that investigators are provided with clearer guidance about updating police forces, police officers and staff throughout the investigation.	Moir Stewart	Mar -14
44	We are carrying out a full review of all our methods for seeking feedback. This will include consideration about how best to gather and learn from feedback provided by officers and staff involved in our investigations.	Kathie Cashell	Aug -14

Ref	ACTIONS	OWNER	TIMETABLE
	Engaging with communities and the public through the media		
45	We will seek to develop better links with people and organisations who work in the community, including groups that have low levels of trust in the police and the complaints system. We will use these links to help identify appropriate representatives for involvement in individual investigations (e.g. through community reference groups).	David Knight	Sep -14
46	We will explore greater use of social media such as Twitter. This allows us to communicate directly to the public in dynamic and fast moving cases and to correct or clarify misleading coverage promptly and robustly.	Sadie East / Charlotte Phillips	In place
47	As we grow and develop, we will review all of our communications strategy, to help us ensure that we can communicate our work, role and outcomes more effectively.	Sadie East / Charlotte Phillips	Mar -15
	Reporting, outcomes and learning		
	Investigation reports		
48	We will implement a new report writing framework and guidance designed to focus investigation reports on the key themes and questions to be answered under the terms of reference. There will be a specific framework for Article 2 investigations. All investigators will receive guidance and training to support them in using the framework.	Moir Stewart	Apr -14
49	As part of our change programme, we will consider creating an enhanced editorial function to ensure our reports are clearly written.	Megan Smart	Mar -15
50	A multi-disciplinary approach, involving commissioners, lawyers and the lead investigator, will ensure that there is effective analysis of the evidence to support robust conclusions.	Moir Stewart	In place
51	We will highlight any areas where we have been unable to gather or test evidence (including non-cooperation from witnesses and issues/failures that relate to other agencies outside our remit) so that these can be tested in further proceedings, such as inquests.	Moir Stewart	In place
	Outcomes		
52	We will publish the outcomes of our investigations, clarifying our own outcomes and those that result from disciplinary or criminal processes.	Kathie Cashell	From May -14
53	We have responded to the Home Office consultation on improving the police disciplinary system and making it more transparent and will continue to make the case for reform.	David Knight	Ongoing
54	We will continue to work with the CPS to ensure we work more effectively to minimise delays. We will consider whether the memorandum of understanding between the two organisations needs revising to reflect any new practice.	Sadie East	Jun -14

Ref	ACTIONS	OWNER	TIMETABLE
55	In our new operating model, we will develop a specialist investigations support function, including staff who specifically liaise with coroners (and other relevant bodies) to ensure full and timely disclosure.	Megan Smart	Dec -14
56	We will also consider whether our memorandum of understanding with the Coroners' Society needs revising to reflect recent developments in legislation and the findings of this review and to clarify our role in inquests.	Sadie East/ David Emery	Mar -15
	Learning and improving police practice		
57	Chief officers will be required to respond formally to our recommendations when the Anti-Social Behaviour, Crime and Policing Bill becomes law. We will put systems in place to ensure that we make best use of this new power and will liaise with police and crime commissioners to ensure that they are aware of our recommendations and the chief officer's response.	Sadie East	Oct -14
58	As part of the change programme, we will develop systems and support and train staff to ensure that recommendations are consistent and informed by best practice and related recommendations made by us or others. This will be supported by improved knowledge management systems.	David Knight/ Megan Smart	Mar -15
59	We are developing an agreement with Her Majesty's Inspectorate of Constabulary and the College of Policing to ensure effective links between our recommendations and standard-setting and inspection.	Sadie East	Apr -14
60	We will carry out thematic work: in 2014/15 on use of force, including the use of restraint and lethal force by the police.	Kathie Cashell	Mar-15
61	If we consider that insufficient action has been taken in response to our recommendations, we will report this to police and crime commissioners and make our views known to ministers and the public.	David Knight	From Oct -14

List of owners

Amanda Kelly	*Acting Chief Executive*
David Knight	*Director of Casework and Customer Service*
Kevin Woodrow	*Director of Resources*
Megan Smart	*Director of Change*
Moir Stewart	*Director of Investigations*
Charlotte Phillips	*Head of News*
Colin Woodward	*Head of HR*
David Emery	*Head of Legal*
Kathie Cashell	*Head of Analytical Services*
Sadie East	*Head of Strategy and Communications*

Glossary

Article 2 (of the European Convention on Human Rights):
Article 2 of the European Convention on Human Rights provides that everyone's life shall be protected by law. This involves both a prohibition on the state taking life (subject to very limited exceptions) and, in certain circumstances, a positive duty on the state to protect life. Sometimes it will be very clear that an allegation engages a person's Article 2 rights – for example, where a person dies while in police detention. In other cases, it may be less clear whether Article 2 is engaged – for example, where the police are alleged to be aware of a threat to a person's life and have failed to take adequate steps to protect that life. If appropriate authorities are unsure whether a matter engages Article 2, they should take legal advice.

Association of Chief Police Officers (ACPO):
Leads and manages the development of the police service in England, Wales and Northern Ireland.

Care Quality Commission:
The independent regulator of all health and social care services in England.

Chief constable:
The chief police officer of a police force.

Chief coroner:
An office created by the Coroners and Justice Act 2009. The head of the coroner system, assuming overall responsibility and providing national leadership for coroners in England and Wales.

Chief Operating Officer (COO):
Chief Operating Officer. A new role that will be responsible for what is currently our casework and investigations work.

College of Policing:
Professional body for policing.

Commission:
The governing board of the IPCC. It holds collective responsibility for governance of the IPCC, including oversight of the executive.

Commissioners:
IPCC commissioners are appointed by the home secretary. They hold prime responsibility for designated police forces and other agencies subject to IPCC oversight.

Conduct:
Conduct includes acts, omissions, statements and decisions (whether actual, alleged or inferred). For example: language used and the manner or tone of communications.

Conferring:
In this document, conferring relates to police officers discussing an incident together before they provide statements or while they write up their witness accounts.

Coroner:
An independent judicial officer, the coroner enquires into deaths reported to him/her.

CRG:
Community reference group.

Crown Prosecution Service (CPS):
Responsible for prosecuting criminal cases investigated by the police in England and Wales.

Custody:
Used to house anyone who has been detained.

Data Protection Act:
Controls how personal information is used by organisations, businesses or the government.

Detention officer:
Responsible for the welfare and safety of detained people.

Dr Silvia Casale:
Responsible for carrying out the independent external review of the investigation conducted by the IPCC into the death in police custody of Sean Rigg.

European Convention on Human Rights (ECHR):
The Convention for the Protection of Human Rights and Fundamental Freedoms agreed by the Council of Europe, 1950.

Family liaison manager:
An IPCC role that acts as a link between a family/complainant and the IPCC's investigation team.

Her Majesty's Inspectorate of Constabulary (HMIC):
Responsible for independently assessing police forces and policing.

Her Majesty's Inspectorate of Policing (HMIP):
An independent inspectorate that reports of conditions for and treatment of those in prisons, young offender institutions and immigration detention centres.

Home Office:
The government department responsible for immigration, counter-terrorism, police, drugs policy, and related science and research.

Home Secretary:
The parliamentary minister for the Home Office.

IAG:
Independent advisory group.

Independently investigate:
An investigation carried out by IPCC staff.

INQUEST:
A charity providing free advice to bereaved people facing an inquest, with a focus on deaths in custody.

Inquest:
A special court hearing to find out how, when and where a death occurred.

Institute for Criminal Policy Research (ICPR):
Carries out multidisciplinary research into crime and the criminal justice system.

Investigator:
An IPCC officer who carries out an investigation

Memorandum of understanding:
An agreement between two or more parties.

Misconduct proceedings:
For a member of a police force or special constable, misconduct proceedings means a misconduct meeting or misconduct hearing. For a person serving with the police who is not a member of a police force or a special constable, misconduct proceedings means any proceedings or management process during which the conduct (as opposed to the performance) of such a person is considered in order to determine whether a sanction or punitive measure is to be imposed against him or her in relation to that conduct.

Mode of investigation (MOI):
Decisions about our level of involvement in an investigation. The different modes of investigation are: independent, supervised, managed, local.

NatCen Social Research:
An independent social research institute that carried out independent research into the views and experiences of bereaved families, IPCC staff and commissioner, police officers and others, for this review.

Near-miss in custody:
Where a death or serious injury has been narrowly avoided.

Police Federation:
The body that represents the interests of all police constables, sergeants, and inspectors.

Police Reform Act 2002:
This act sets out how the police complaints system operates.

Post-mortem:
A medical examination carried out on a person who has died to try to find the medical cause of death.

Prisons and Probation Ombudsman (PPO):
Independent ombudsman who investigates the complaints of prisoners and probationers.

Protected characteristics:
Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Referral:
The IPCC must be notified about specific types of complaint or incidents to be able to decide how they should be dealt with.

Rigg review:
The independent external review of the investigation conducted by the IPCC into the death in police custody of Sean Rigg.

Section 17 of the Regulation of Investigatory Powers Act 2000 (RIPA):
Exclusion of matters from legal proceedings: www.legislation.gov.uk/ukpga/2000/23/section/17

Section 22:
Currently being consulted on under section 22 of the Police Reform Act. Our draft guidance sets out our expectation that when there is a death during or after police contact, key police witnesses should be separated before providing their accounts and should not confer.

Statutory guidance:
Published guidance which is one of the ways that the IPCC assists local policing bodies and forces to comply with their legal obligations and achieve high standards in the handling of complaints, conduct and deaths and serious injury matters.

ipcc
independent
police complaints
commission

Independent Police Complaints Commission (IPCC)
90 High Holborn
London
WC1V 6BH

Tel: 0300 020 0096
Email: enquiries@ipcc.gsi.gov.uk
www.ipcc.gov.uk

March 2014