RESPONSE TO INDEPENDENT REVIEW OF

DEATHS AND SERIOUS INCIDENTS IN CUSTODY

6 MAY 2016

Introduction

A. The CBA represents the views and interests of practising members of the criminal Bar in England and Wales.

B. The CBA's role is to promote and maintain the highest professional standards in the practice of law; to provide professional education and training and assist with continuing professional development; to assist with consultation undertaken in connection with the criminal law or the legal profession; and to promote and represent the professional interests of its members.

C. The CBA is the largest specialist Bar association, with over 4,000 subscribing members; and represents all practitioners in the field of criminal law at the Bar. Most practitioners are in self-employed, private practice, working from sets of Chambers based in major towns and cities throughout the country. The international reputation enjoyed by our Criminal Justice System owes a great deal to the professionalism, commitment and ethical standards of our practitioners. The technical knowledge, skill and quality of advocacy all guarantee the delivery of justice in our courts, ensuring that all persons receive a fair trial and that the

adversarial system, which is at the heart of criminal justice in this jurisdiction, is maintained.

D. This is the CBA's response to the Independent Review of Deaths and Serious Incidents in Police Custody call for submissions:

1. **In what ways could the risk of death/serious incidents in police custody be avoided?**

   We would advocate the following:

   Early assessment of both physical and mental health.

   Access to treatment for the detained person by liaison with appropriate agencies.

   Effective monitoring of the well-being of detained persons and appropriate support by suitable professionals.

   Provision of access to communication with family members / support networks.

   Training for those tasked with detention to monitor and promote safe-guarding to include general issues of well-being as well as particular issues that arise.

   Consideration and adaptation of the environment in which the detained person is detained; we are of the view that the architecture and atmosphere of police custody can add to the mental stresses and strains of the detained person.

2. **What actions could be taken by the police to avoid or reduce the risk of death/serious incidents following or as a result of police use of force, with particular reference to the use of restraint?**

   We would suggest the following:

   Appropriate and regular training as to the use of force and restraint and appraisal of restraint techniques.

   Follow up monitoring of any individual subject to restraint.

3. What **actions could be taken by the Police and other organisations to reduce the risk of self-inflicted deaths within 48 hours of police custody?**

   We would propose the following:

   Initial assessment by FME be by a doctor trained to detect particular issues (such as mental health, autism, ADHD etc) with referral to a specialist if need be.

Assessment by FME to be focused on well-being rather than simply whether a person is fit for the police investigation to proceed immediately.

Early assessment to concentrate on both physical and mental health.

Access to treatment to be afforded by liaison with appropriate agencies.

Provision of access to communication with family members / support networks and consultation by the police with those family members / support networks.

Effective monitoring of well-being of detained persons and appropriate support provided (i.e. rather than simply checking on the physical health of a detained person, as is often seen on a custody record, time could be allowed for a check by someone independent to the police with regard to general well-being).

Training for those tasked with detention to monitor and promote safe-guarding to include compliance with the spirit of the provisions of PACE as well as the letter of those provisions.

Training in negotiation for those tasked with detention to deal with difficult or volatile situations.

Real consideration to be given to whether, in fact, a person needs to be detained within police custody and scrutiny of the authorisations to detain.

4. To what extent is mental health a factor and how do you think this should be addressed?

We are of the view that mental health can be a major factor in terms of injury and even death in custody.

We would advocate that:

Early assessment of the detained person takes place by appropriate professionals.

Liaison takes place between appropriate agencies to ensure that each involved in the detained person's case is appraised of any issues with mental-health.

Support is afforded to individuals in custody by trained professionals.

Training in mental health is provided to the police to focus on understanding the warning signals and responding accordingly.

Consideration be given to mandatory legal advice by mental health specialists.

5. **To what extent is ethnicity a factor, why, and how do you think this should be addressed?**

   We are of the view that ethnicity can be a major factor, particularly if there are issues of isolation and / or issues of communication.

   We would advocate that:

   Early assessment of needs take place.

   Support is provided by personnel that can identify with the needs of the individual.

   Training is provided to the police in terms of issues of ethnicity, culture and the particular needs that these may trigger.

   Consideration be given to mandatory legal advice.

6. **To what extent are drugs/alcohol a factor and how do you think this should be addressed?**

   We are of the view that drugs / alcohol can be a major factor, particularly if there are issues of withdrawal accompanying the detention.

   We would advocate that:

   Early assessment of needs takes place.

   Appropriate medical intervention is provided and support be given by trained professionals.

   Consideration be given to mandatory legal advice.

7. **What specific considerations should be given to children and young people in custody to reduce risk of death/serious harm?**

   We believe the following should be considered:

   Allowing communication and contact with family members / wider support networks where appropriate.

   Providing a be-friender service to the child / young person.

   Providing designated trained appropriate adults.

   Access to mandatory legal advice by youth specialists.

8. **Are there any other issues that affect other vulnerable groups?**

   We are of the view that there are often issues of isolation / lack of understanding of the process amongst those with language difficulties and / or those from different jurisdictions.

   In addition, we are of the view that there are often similar issues amongst those with learning difficulties or with vulnerabilities such as ADHD / Autism.

9. **Do you have any suggestions on how the police and other agencies could improve the ways in which they work together so as to prevent or reduce the risk of deaths and serious incidents? For example, medical services within the police station, the ambulance service, mental health detention services, mental health community services, drug and alcohol support services.**

   We would suggest:

   Appropriate inter-agency training and liaison.

   Medical services at the police station to include those trained to identify and deal with physical and mental health issues.

   Diversion to support agencies that have access to the detained person.

   Appropriate ongoing and consistent support.

10. **Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families' needs and expectations. If so why do you think this is, with particular reference to:**

    a. **Family liaison**
    b. **Police statements in the media**
    c. **IPCC investigations**
    d. **Role of the Crown Prosecution Service and the criminal justice process**
    e. **Coroners' inquests**
    f. **Police misconduct and disciplinary process**
    g. **Investigations by NHS Trusts or other medical healthcare providers**
    h. **Role of the Health and Safety Executive**

    We are of the view that concerns can arise if there is a lack of transparency, or a perceived lack of transparency, in the system. As a result, we are of the view that early communication with families / support networks and ongoing liaison are vital. Such communications should be able to explain sensitively what has occurred, what the investigation will involve and what the role of each agency will be.

11. In what ways could family experience, involvement and support be improved at all stages after a death has occurred?

We would suggest:

Ongoing support and transparency.

Private and public acknowledgements of mistakes / errors.

Private and public acknowledgements of matters learned and how the system will be adapted if mistakes / errors are made.

12. If someone you know has died in such circumstances or if you have had an experience in police custody that resulted in, or could have resulted in, serious illness, injury or self-harm please set out what happened at each stage of the incident. What went wrong and what could have been done differently?

N/A

13. What could be done to improve accountability on the part of the police in relation to deaths and serious incident in police custody?

We would suggest the following:

Transparency of practice to detained persons, their families and the public.

The need to observe and record matters of concern as they arise.

Encouraging staff to work together but also allowing and supporting police personnel to raise any concerns and offering a supportive and safe environment to do so.

Multi-agency post-incident analysis and implementation of matters learned.

14. What could be done to improve sustained learning from deaths and serious incident in police custody?

We are of the view that multi-agency post-incident analysis and implementation of matters learned would assist.

15. How can there be more effective implementation of learning and recommendations arising from investigations and inquests into deaths?

We would suggest multi-agency post-incident analysis and subsequent reviews to ensure matters learned have been acted upon appropriately.

16. We need to learn where things have gone wrong, but we can also learn from things that have worked well. Do you have any examples of good practice which has lead to positive outcomes? This could be in preventing a death or serious incident, the family involvement in the investigation and/or its outcome?

We have seen how early intervention with, for example, mental health teams, can be a valuable support both to the individual and to those responsible for that individual's detention.

17. Are there any other comments you would like to make?

We are mindful of the ongoing good work of the various agencies involved in the detention of individuals which we acknowledge brings with it a plethora of demanding issues. We support and encourage ongoing development in this area.

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