Update on the action plan from the *Review of the IPCC's work in investigating deaths*

Contents

1. Introduction

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

For that reason, in 2012 we decided to conduct a comprehensive review of our work in this area. This followed criticism and concerns about the approach, timeliness and thoroughness of some of our investigations. In March 2014 we published the final report of our review. The report included the feedback we had received and the actions that we would put in place to deal with the concerns raised during the review.

The report included 61 actions, 22 of which we had completed before the report was published. The findings of the review matched many of the concerns raised in Dr Silvia Casale's review into the investigation of the death of Sean Rigg. We therefore combined our action plans for both of these reviews to monitor and report on implementation.

2. Purpose of the update report

This update report is a summary of the progress we have made with implementing our action plan. It follows the same structure as the final report, with information categorised under the following headings:

- independence
- scope and remit
- initial steps in assessment and investigation
- conducting the investigation
- engagement during investigations
- reporting outcomes and learning

Section 5 of this report includes a number of additional actions that we will deliver through our change programme over the next three years.

3. What we have delivered

3.1 Independence

Concerns were raised during the review about the perceived independence of the IPCC. This included not appearing sufficiently independent of the police service or police culture or where we have been perceived to treat the police more favourably. This criticism focused on the number of ex-police officers working for the IPCC and the diversity of IPCC staff more generally. The actions we committed to cover the following areas:

- increasing the diversity of IPCC staff
- developing a multi-disciplinary approach to investigations where staff from different teams (for example, legal and communications) are more involved in investigations into deaths
- addressing obvious conflicts of interest
- promoting a culture of independence and demonstrating our values

Progress against actions

We recognise that we need to draw on the specific skills and expertise of those who have served with the police and have recent experience of carrying out criminal investigations. However, we also recognise the benefit of a diverse range of backgrounds amongst our staff in providing different perspectives on our work.

We have conducted a significant rolling programme of recruitment and we have worked closely with our external recruitment provider to make sure it is making every effort to increase the diversity of our current workforce in relation to their previous employment and how they reflect the diversity of the population. This recruitment has increased the number of staff employed by the IPCC by nearly 50 per cent compared with the number we employed in January 2014.[1] Our current number of staff is 795.

Following the recent restructure of our operations function, the most senior members of the management team, which includes a chief operating officer, director of investigations and two deputy directors of operations, are all from a non-police background. This senior management team will build on the progress found in this report and is responsible for making sure that effective systems of management, appraisal and training support all our values and a culture of independence.

Of the new staff we have recruited there are 151[2] investigators. This has reduced the percentage of staff in the investigations directorate who have worked for the police from 40% (28% as police officers) to 34% (20% as police officers)[3]. The first group of new investigators completed their initial training in October 2014 and the second group of new investigators started in November 2014 and finished their initial training at the end of December.

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1 On 22 January 2014, the IPCC employed 538 of staff including staff working on the Hillsborough

2 Includes Trainee Investigators, Investigators, Lead Investigators and Deputy Senior Investigators

3 Staff breakdown correct as of 13 March 2015.

We have recently developed our policy about conflicts of interest which will introduce a clearer test for staff and commissioners to report conflicts of interest. This includes specific guidance about when declarations should be made to withstand scrutiny and show that our decision-making is free from bias. To help identify these situations, the policy gives a range of examples of potential conflicts. The revised policy will come into effect in April 2015. All staff will be asked to update their conflict of interest records. This new policy will feed into future training for all new staff.

We have also introduced a policy on declaring previous employment with the police or other bodies under our jurisdiction. We value the skills and experience that former police officers and police staff bring to our organisation, but it is critical to public confidence in the IPCC and in the wider complaints system that the perception of the impartiality of IPCC investigations is not compromised by a close connection between the person leading an investigation and those being investigated. It is also in the interests of the IPCC staff member not to allow the possibility of such a perception to arise. The same considerations apply to others who may have a role in making key decisions in relation to an investigation, such as approving terms of reference or signing off final reports.

To reduce the risk of a perceived lack of independence, the circumstances in which investigators can lead an investigation into a force for which they have previously worked will be restricted. The policy also restricts the likelihood of them taking any significant decisions relating to the course or outcome of that investigation, such as approving terms of reference or signing off final reports. In most circumstances there will be a three year time bar on leading investigations into a force for which they have previously worked. Any exception to this rule can only be applied with the agreement of the director of operations or the chief operating officer, and will be monitored on a regular basis. Potential exceptions could include:

- An investigation that requires specialist skills, knowledge or training unavailable elsewhere.
- The role in which the ex-officer was employed was so junior, so brief, so distant in time, or so removed from the body currently under investigation that no suggestion of lack of impartiality could reasonably be drawn.
- A member of staff is on call and is sent on an urgent referral – the member of staff should be re-deployed at the earliest opportunity, while maintaining the continuity and integrity of the investigation

Continuing work

We are developing our training to staff to include content on identifying and challenging personal bias and will be delivering this training during the new financial year.

3.2 Scope and remit

This section of the final report considered whether the IPCC's investigations into deaths were broad enough to answer the key questions about why someone died. The actions we committed to covered the following areas:

- considering the interaction between the police and other agencies in death investigations
- passing information to the coroner and other oversight bodies where relevant

Progress against actions

We have updated the guidance for investigators on writing terms of reference for our investigations. The guidance now states that where there has been a death during or following contact with the police and there has been any interaction with other organisations, this may need to be considered to answer all relevant questions and concerns. The terms of reference should reflect that the investigation will examine any relevant interaction between the police and other agencies.

Case study

A man suffered two epileptic seizures while in police custody, where he was held for 33 hours. He had a third fit in a cell at a magistrates' court after being transferred there for a court hearing and died in hospital three days later.

The terms of reference for the investigation included:

"The investigation will examine whether the response by any medical practitioners contracted by the police was appropriate to the circumstances."

The investigation found that there were opportunities which were missed by clinicians and that there were issues in communication between police and clinicians. The IPCC recommended that the communication issue, along with other issues identified, should be considered as a training issue for the officers and staff involved.

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. The IPCC has agreements and Memoranda of Understanding (MoU) with several other oversight bodies. We are always mindful of the need to work effectively with other oversight bodies to make sure that we, and they, are able to carry out our investigations effectively.

Case study

The IPCC conducted an independent investigation into the death of a man after he was arrested on suspicion of drug related offences and taken to custody. When the police van arrived at the station the man was visibly unwell and was taken by ambulance to hospital where he died. During our investigation it was found that a single crewed ambulance was sent to the police station which was unable to take the man to hospital and there was a delay in arrival as the ambulance satellite navigation system had directed the ambulance to the wrong location. A second ambulance which could have taken the man to hospital was 18 miles away. Neither of these delays in response were communicated to the police force by the ambulance operators.

Additional delay was also caused in the man's treatment as the ambulance operator informed the wrong hospital of the ambulance's arrival when it was going to an alternative hospital. We have raised these issues to the coroner to consider as part of the inquest.

Continuing work

In April 2015 the Home Office will put in place regulations which give the IPCC jurisdiction over contractors working for the police. This will mean that, as much as possible, contractors (for example those working in custody suites or as call handlers) will be given the same level of scrutiny as police officers and members of police staff. We will make sure our investigators have the relevant guidance and training to put these new powers into practice.

From April 2016, healthcare in police custody will be commissioned through the National Health Service, and that will allow clinical reviews of healthcare provision to be carried out in parallel with our own investigations. We are discussing with NHS England how best to do this

3.3 Initial steps in assessment and investigation

3.3.1 Referrals and assessment

This section of the final report considered 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. The actions we committed to covered the following areas:

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

Progress against actions

We wrote to chief constables to remind them of their duty to refer deaths immediately so any delay does not undermine the independence and integrity of the investigation. Where this has not happened we have included the delay in the terms of reference for the investigation. The delay has then been considered as part of the investigation, including whether there is any potential misconduct by those who delayed the referral.

Case study

A man was restrained during a disturbance where he became unwell and an ambulance was called. The duty officer arrived at the scene at 7.25am and officers returned to a police station to write their accounts in the company of one another. The professional standards department who would have responsibility to refer the matter to the IPCC was told of the incident at 10.30am. The matter was referred at approximately 2.30pm and was declared an independent investigation. The man sadly later died in hospital.

As part of the terms of reference for the investigations the IPCC looked at the actions and decisions made following the incident up to the referral to the IPCC, as there were concerns over the delay between the incident occurring and the referral to the IPCC.

While investigating the delay of the referral, the IPCC interviewed two individuals under criminal caution for perverting the course of justice due to the post incident procedures followed. As a result of the investigation one officer will be facing a misconduct meeting for the delay in referral to the IPCC.

We have established a new assessment team which acts as a single point of entry into the IPCC and provides a vital triage function for all of our operational work. The team's role is to assess referrals, make decisions on whether and how we investigate a case and to make sure that we identify the resources, skills and expertise needed for any investigation we conduct. We are now working to make sure that we realise the benefits of having a single team in one location, including improved consistency and the identification of trends and learning which will feed into our decision-making process.

Continuing work

As part of developing how we will operate when we have to investigate significantly more cases, we are currently developing the criteria we will consider when we make a decision about whether and how a case should be investigated. When complete we will publish the IPCC's key considerations for decision-making about referrals.

3.3.2 Post incident management

This section of the final report considered the initial management of the scene and evidence, including witness accounts. The actions we committed to covered the following areas:

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

Progress against actions

The work the IPCC has been doing in this area has influenced and encouraged public debate on post-incident management. This has included discussion about how perception and public confidence in policing can be affected if there is an opportunity for officers to confer before providing a statement. There has also been discussion of the scientific evidence about how the best evidence can be obtained from officers.

We have drafted and consulted on statutory guidance on achieving best evidence in death and serious injury investigations. The draft guidance 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 states that key policing witnesses should be separated before providing their initial accounts and that they should not confer. We are now developing finalised guidance for approval by the Home Secretary.

The Court of Appeal, in relation to the cases of Mark Duggan and Rafal Delezuch, has also considered matters related to conferring and separation of officers. The IPCC provided evidence for this hearing. The Court of Appeal assessment was that our draft guidance has much to commend it and would minimise the risk of police officers colluding following an incident in which someone has died or suffered a serious injury. In particular, the judgment said that the combined effect of the provisions about identification of the key policing witnesses, the separation of witnesses and the ban on conferring would reduce the risk of collusion.

We have continued to provide additional independent oversight at the scenes of incidents where appropriate and possible, and we have been exploring whether filming can take place during the preservation of the scene and securing of evidence. We are developing the IPCC's position on the use of body worn video as well as considering whether we should include filming in our statutory guidance around achieving best evidence.

Investigators have received further training and guidance on scene management to make sure that they have the skills and confidence to take control of a scene, both remotely and on arrival, and to give guidance to the police and contracted forensic providers. Guidance to support the training will be included in our revised operations manual.

Case study

Examples of the actions taken at scene by the IPCC include:

- *Following a referral to the IPCC of a man who had died following police contact, the IPCC went to the scene and contracted an independent forensic biologist to examine and analyse the blood spatter patterns.*

- *Following a non fatal shooting, the IPCC asked police to shut off the scene of the shooting and agreed a forensic strategy with the police force. A ballistic expert was independently instructed by the IPCC to provide expert opinion around the interpretation of the complex scene.*

Continuing work

We are using consultation feedback and the Court of Appeal judgment to produce a final draft of our statutory guidance that provides a better basis for public confidence in this process, but is also able to be applied in practice by the police. The guidance will be considered by the Commission in spring 2015 and then sent to the Home Secretary for approval. We hope to publish this in summer 2015.

3.4 Conducting the investigation

This section of the final report considered how the IPCC carries out investigations, including how we collect and analyse evidence, interviews with police officers and others, specialist skills and expertise, and investigating discrimination. The actions we committed to covered the following areas:

- use of investigation plans
- use of IPCC powers
- investigating discrimination
- use of experts
- mental health

Progress against actions

IPCC investigators have been trained to produce comprehensive investigation plans for all new independent investigations. Investigation plans set out how information and evidence will be gathered and how the investigation will be progressed in order to meet the terms of reference. We have developed a template to support IPCC investigators develop high quality investigation plans and our revised operations manual will include additional guidance. IPCC managers are responsible for making sure that their staff produce high quality investigation plans, and the quality and effectiveness of plans will be reviewed regularly by the IPCC quality team.

Operational staff have received training on our powers to make sure they understand, and feel confident to use, the powers that are available to them.

Staff have fed back the following regarding the training they received:

- Scene management training - “practical experience of dealing with a scene in a safe environment was invaluable”.
- Use of powers training –“good examples from trainers to show how powers apply to IPCC cases”.
- Disclosure training – “examples relating to real life investigations were really helpful and put theory into context”.

This has been built into the training plan for all new investigators. Guidance reinforcing this training will be included in our revised operations manual. The training covers areas such as:

- powers to seize and retain evidence
- compelling police witnesses to attend an interview
- powers of search and arrest

The Anti-Social Behaviour, Crime and Policing Act 2014 created a new power for the IPCC to require third party individuals or organisations to provide us with information which is reasonably required for the purposes of an investigation. We expect this power to come into force in April 2015.

We proposed to the College of Policing that the police code of ethics should include a duty for police officers to co-operate fully with IPCC investigations, especially when the investigation concerns the most serious incidents, such as when someone has died in police custody. Although this was not incorporated into the code of ethics, we will re-visit this issue with the College of Policing if, and when, the code is revised. We strongly believe that full and prompt co-operation with investigations is important for the quality of the investigation and public confidence. We re-iterated this in our response to the recent Home Office consultation on the police complaints system.

In its response to this consultation, the Government announced its intention to introduce a duty of candour to ensure that police officers understand their obligations to cooperate fully with any IPCC investigations. The Police Conduct Regulations will also be amended to introduce a specific requirement to co-operate with an IPCC investigation.

Concerns were raised during our review about the IPCC’s thoroughness in identifying and addressing issues about perceived discrimination in our investigations. Training has been given to all investigations staff on discrimination law and this has been included in the training plan for new investigators. Guidance in our operations manual about drafting terms of reference has been updated to make sure that consideration is always given to whether there are any possible discrimination issues which require attention as part of the investigation. We have also provided training to our operational staff drawing on the recommendations we made to forces following our review of the handling of discrimination complaints we published in June 2014.

We are revising our guidance on how allegations of discrimination should be handled. This guidance is for the police and the IPCC to use when investigating and

resolving allegations of discrimination against the police. We are being helped in this work by an external reference group which includes a member of the Discrimination Law Association, a representative of the Equality and Human Rights Commission, and a member of the public with experience of making a complaint about discrimination. We are carrying out a wide range of engagement activity with the aim of producing guidance which supports the police in dealing with allegations of discrimination. To do this we are discussing it with users of the guidance in police forces, community and voluntary groups, people who have made complaints about discrimination and people who have been subject to complaints. We aim to publish the revised guidance in summer 2015.

We have also been taking steps to increase our knowledge and awareness about current mental health issues. We have engaged with key organisations that have expertise in this area, and we have reviewed our own work to identify trends and issues which require more in-depth work.

We have continued to underline the importance of mental health support to policing in our public statements, in our engagement with ministers and through the Ministerial Board on Deaths in Custody and the Independent Advisory Panel. We have also worked to improve our staff's knowledge about mental health and make sure this is considered, where appropriate, in our investigations. To support staff in this we held a learning and development day and we have run continuous professional development days for staff and commissioners on the subject of mental health. We have also invited stakeholders with experience and expertise on the subject of mental health to discuss their work with our operational staff and commissioners. The aim of the sessions was to provide an overview of current developments around mental health and policing and to increase knowledge about mental health service users, including complainants with mental health issues.

Continuing work

We are considering how we can make best use of experts in our new operating model and guidance on this will be incorporated into our revised operations manual.

We have recently appointed a new head of quality who will be responsible for leading a proactive quality assurance function that reviews all of our operational work. This function will be developed through 2015.

3.5 Engagement during investigations

3.5.1 Engaging with families

This section of the report considered how we engaged with bereaved families during an investigation into a death. The actions we committed to covered the following areas:

- our overall approach to engaging with families
- family liaison roles

- involving and updating families throughout the investigation
- getting feedback and learning from families' experiences

Progress against actions

To make sure that all our interactions with families during an investigation are professional, respectful, sensitive and responsive to families' needs, we have delivered continuous professional development training on bereavement to all our investigators and commissioners. This training included the stages of grief and used case studies to explore how investigators could put this knowledge into practice. This has meant that our dealings with families are informed by the understanding that they are grieving and have experienced a sudden and unexpected bereavement in highly traumatic circumstances. We have built bereavement training into the training package for all new investigators to make sure that they are aware of how a prolonged and lengthy investigation, as well as the coronial process, can affect the bereavement process. Staff provided the following comments regarding the bereavement training:

- "Very informative, made me think about the way I deal with bereaved families and consider issues that I may not have otherwise thought about".
- "The exercises and case law assisted in helping to think about different emotional impacts, especially of very dramatic news or with differing situations. Use of anecdotal information was very useful for deeper consideration".
- "Brought considerable clarity to difficult area, well presented".
- "Provided a good overview of issues relevant to the IPCC from the perspective of someone with experience of being at the other end of an IPCC investigation".

We are currently reviewing our family liaison model as part of our change programme. However, in the meantime we have made some changes to the way in which we carry out investigations to make sure that there is clear consideration of the needs of families, and that the family is involved in the investigation, as well as making sure that families receive as much information as possible about what happened to their family member.

Case study

The IPCC investigated the death of a young man who became unwell while being restrained by police and subsequently died.

Following the inquest into his death, the family of the young man contacted the IPCC lead investigator to express their thanks for the sensitive and humane way the case had been handled, including keeping them up to date and answering any questions they had.

Guidance to investigators includes offering families the opportunity to meet with IPCC staff and the case commissioner at the beginning of the investigation. It also states that this opportunity should be offered throughout the investigation. To enable

families to raise any concerns they have with the progress of the investigation or the interaction with the IPCC, they are provided with the contact details of the lead investigator's manager and when appropriate the manager will make contact with them directly. This allows the manager to deal with any issues as they arise. We have continued, wherever possible, to provide press statements to families before circulation so they can express any concerns with the content.

Case study

After starting an independent investigation into a death following police contact of a young man, the lead investigator for the case visited the man's parents on two occasions to introduce himself and to explain the processes the IPCC would follow during the investigation. The family also had regular visits from a dedicated family liaison manager throughout the investigation.

The manager of the investigator spoke to the father of the man to discuss the contact he had during the IPCC investigation since the death of his son. He informed the manager that he was happy with the level of service he had received.

To make sure our investigators follow this approach we have included in all investigators' performance reviews an assessment of their work with families. This reinforces the fact that effective engagement with families is a vital component of IPCC work. To monitor this, investigators reflect on their relationships with families at regular meetings with their managers and also include an assessment of the effectiveness of those relationships in updates to the case commissioner.

We have developed an information pack in simple language and in consultation with INQUEST, about the investigation process and the coronial process to supplement the initial information leaflet and letters that we provide to support families during our investigation. The information pack is provided to all family and friends following a death.

We have continued to seek the involvement of families in developing the terms of reference for the investigation to make sure that they are as engaged as they can be, or want to be, in the investigative process. This has allowed families to ask any questions about their relative's death and fulfils the requirement under Article 2 of the European Convention on Human Rights that they are involved in the investigation.

Case study

Following a death in custody, the investigator met with the family of the man who had died to discuss with them the terms of reference for the investigation. The family expressed concerns that they had seen facial injuries on the man following his death and, because of this, they believed he may have died as a result of a police assault. This was included in the terms of reference and the investigator fast tracked the viewing of all CCTV within custody and asked the pathologist to comment on these injuries.

It was quickly established that the cause of the injuries was self inflicted by the man while in custody and there was no suggestion or evidence of assault. This information was passed to the family as soon as evidence was considered and their initial concerns were addressed.

It is important that families are provided with emerging findings throughout the course of an investigation so they are aware of the likely outcome, but also so they can see how we have addressed their questions and any concerns about factual accuracy. As stated earlier, it is now standard practice to create an investigation plan for all new investigations. Investigators refer back to the investigation plan to help them draft meaningful updates on progress and emerging findings of the investigation.

We have delivered training to investigators on disclosure and we have updated guidance to staff about updating families and disclosing all information, subject only to the 'harm test'. At present our legal advice is that under the terms of the Police Reform Act, we cannot share draft reports, but we are considering this further. We have also revised our final report template, which includes a section where the investigator is required to demonstrate how the questions that have been raised by the family have been addressed during the investigation. We are using these for all investigations into deaths.

Continuing work

Work to review how we get feedback on our investigations and interaction with families is well underway. We have established a customer experience working group and we are planning a further family listening day which will involve key people from our operations directorate.

3.5.2 Engaging with the police

This section of the final report considered how we engage with the police during an investigation into a death. The actions we committed to covered the following areas:

- dealing with the media
- communication during an investigation
- getting feedback

Progress against actions

Our investigators have a responsibility to keep interested parties and the subjects of an investigation updated throughout. We have reviewed our guidance for investigators on interested parties and subjects, to make sure that they provide meaningful updates during an investigation, and we will continue to share advance copies of press releases with relevant forces on all investigations, as well as the relevant Police and Crime Commissioner when the investigation relates to the Chief Constable.

Continuing work

We are conducting a full review of all our methods for seeking feedback which includes how best to gather and learn from feedback provided by officers and staff involved in our investigations.

3.5.3 Engaging with communities and the public through the media

The way we engage with communities and the wider public has important implications for public confidence, both in our investigations and in the police complaints system as a whole. This section of the final report considered how we engaged with communities and the public through the media. The actions we committed to covered the following areas:

- better links with people and organisations working in the community
- greater use of social media
- reviewing our communications strategy

Progress against actions

In July 2014 we published our oversight and confidence strategy and our engagement strategy which are available on our website. These strategies set out our objectives and the actions we will deliver in 2014/15. One of the specific actions in the engagement strategy is:

We will agree a consistent approach to community and stakeholder engagement during critical investigations, including:

- *how to undertake a community engagement assessment*
- *the use of community reference groups*
- *the use of bulletins, public meetings, and forums to keep communities informed of progress*

This work is currently underway and an initial proposal will be considered by our Management Board in March. Alongside the development of this proposal we have been increasing our focus on community and stakeholder engagement in general and during current critical investigations.

We have identified that there are low levels of trust in the police and the complaints system for certain sections of the community. As this is particularly evident for young people we held three youth engagement events in England and Wales. These sessions helped us to understand young people's perceptions and experiences of the police. We are feeding the key messages back to the police forces in the areas where the events took place. We have also held a community engagement session in our Birmingham office and we will be carrying out further stakeholder engagement sessions in 2015/16.

Case study

The IPCC public confidence survey 2014 identified that:

- *Young people aged 15-24 are less likely to be happy with the way police treat them, are less willing to complain if they are unhappy, and are less likely to feel that the police will deal fairly with complaints.*
- *Although young people's awareness of the IPCC is increasing (35% in 2014 compared to 21% in 2004) they remain significantly less likely to have heard of the IPCC than the rest of the population (64% overall).*

In addition, our annual complaints statistics for 2013/14 show that only 8% of complainants are under 24, despite this being an age group that has high levels of contact with the police.

In response to this evidence we decided to hold a series of youth engagement events across England and Wales, building on an earlier pilot event held in London. After London, these events were held in Cardiff, Birmingham and Bradford.

The events were designed to help us:

- *Find out more about the issues affecting young people's trust and confidence in the complaints system and the police more generally.*
- *Identify ways to help raise young people's awareness of how to complain.*
- *Identify new ways for us to engage with young people and involve them in our work moving forward.*

We recognise that face-to-face engagement of this type is not enough to make a significant impact on young people's awareness and confidence. However, undertaking a small number of regional sessions has helped us to gather useful evidence to inform our wider approach to making sure that the complaints system meets the needs of young people.

Now that the events have taken place, we are meeting with a range of stakeholders, including leads in children and young people and professional standards for each of the force areas covered by the events, to brief them on the key messages.

The IPCC has had a Twitter account for some time which has focussed on sharing information about IPCC investigations and ongoing work. Over the last 12 months, in

order to improve our communication directly with the public in an accessible, dynamic and fast moving way we have:

- Opened a second Twitter account staffed by our customer contact centre to provide advice and to respond to queries regarding the complaints system. In the first seven weeks the team responded to 60 individual enquires through this account.

- Used infographics and podcasts to allow people access to our information in different ways. The level of engagement with the infographics was approximately 2.5 times higher than the content that did not have any infographics with it. The podcasts have currently been listened to more than 1000 times.

- Encouraged conversations with those who question our work through social media. We also identify and target influential users to help increase the reach of IPCC messages. These have helped to nearly double our social media audience.

We recognise that although progress has been made in this area of communication there is more that can be done. Therefore, we will be introducing a new dedicated digital team as part of the expansion and re-organisation of our communication functions.

Continuing work

We will continue to develop our approach to community engagement for the most serious and sensitive investigations. We are establishing a stakeholder reference group for our Change Programme to share ideas and provide us with feedback. The reference group will include representatives from community groups and the voluntary sector. We will also deliver a series of stakeholder engagement events in different locations in England and Wales focussing on the voluntary and community sector and other relevant stakeholders. This will provide an opportunity to feed in to our current work and we will use these events to inform how we carry out this type of engagement in future.

3.6 Reporting, outcomes and learning

3.6.1 Investigation reports

This section of the final report considered the quality, accessibility and sharing of our investigation reports. The actions we committed to covered the following areas:

- the structure of our investigation reports
- disclosure and publication of reports
- highlighting issues to inquests

Progress against actions

We have continued to work in a multi-disciplinary way during our investigations. This involves commissioners, lawyers and the lead investigator working together on developing and agreeing investigation strategies, analysing the information collected during our investigations, and using the evidence to support our conclusions. It also provides a means of robust internal challenge during the course of the investigation.

We have been trialling a new framework for our final reports. The framework has been designed to focus on the key themes and questions that have been set in the terms of reference. A separate framework has been developed for Article 2 investigations, including how the specific requirements of Article 2 have been met, and how the family's concerns or questions have been addressed.

Continuing work

We will train all staff on how to use the final report framework, which we plan to implement by summer 2015. We are also recruiting staff to provide editorial support to make sure that our reports are well written, clear and can be understood by people who are not familiar with police processes or the complaints system.

3.6.2 Outcomes

This section of the final report considered the processes that take place as a result of our investigations. Actions we committed to cover the following areas:

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

Progress against actions

We are currently collating data on the outcomes from disciplinary and criminal processes from our investigations and are considering how this can feed in to our annual report. We have continued to publish our own outcomes and those of both criminal and disciplinary processes through our press releases on individual cases.

Case study

We have issued press statements regarding our cases which have included the following:

- *The IPCC found a case to answer for gross misconduct against five officers in relation to events before the death of a man. The officers will now face misconduct hearings.*

- *After receiving the files and further work being undertaken by the IPCC, the Crown Prosecution Service (CPS) has decided that a custody sergeant and two detention officers should be charged with unlawful act manslaughter, gross negligence manslaughter and misconduct in a public office following a death of a man who was restrained in police custody.*

- *After a man died as the result of falling from a building the IPCC investigation concluded that the man's death was a tragic accident and that it was reasonable to conclude that he fell from a balcony while either jumping or climbing from it. No misconduct issues against any officers were found.*

To make sure that delays are minimised during our investigations we have continued to meet with senior staff in the CPS on a quarterly basis to help with the handling of difficult and complex cases and to help us work more effectively together. During our regular meetings we have considered whether any of the issues raised as part of the IPCC's review of cases involving a death require the Memorandum of Understanding between the two organisations to be revised.

We continue to engage with the CPS at an early stage of our investigations when potential criminality is identified to provide 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.

Case study

Following a stop of a car, a man ran into a neighbouring garden. A search was made of the rear of the garden using police dogs. While the search was ongoing the police dog, which was not leashed, entered the property and attacked the owner of the property who sustained injuries to her right arm and leg. She was taken by ambulance to hospital where she later died.

Early CPS advice was sought in relation to the following criminal offences:

1. *Gross Negligence Manslaughter (for the dog handler)*
2. *Misconduct in Public Office (for the dog handler)*
3. *Section 3 Dangerous Dogs Act 1991: (For dog handler and chief constable)*
4. *Corporate Manslaughter (for the police force)*
5. *Section 3 Health and Safety at Work Act: (for the police force)*

Early advice was used to inform the investigator's decision about lines of enquiry and the evidence to seek. We are currently considering three of the offences.

We have begun to consider possible revisions to the content of the MoU with the Coroners' Society in liaison with coronial parties. The purpose of the MoU is to make clear the working relationship between the IPCC and coroners where the IPCC is involved in an investigation into a death of a person which involved contact with the police.

3.6.3 Learning and improving police practice

This section of the final report considered how we make sure our work prevents future deaths and contributes to improvements in police practice. Actions we committed to cover the following areas:

- making and following up recommendations
- working with Her Majesty's Inspectorate of Constabulary (HMIC) and the College of Policing
- working to improve police practice to prevent future deaths

Progress against actions

On 1 October 2014 a statutory framework for organisational learning recommendations made by the IPCC came into effect. This creates legal obligations for recipients of our organisational learning recommendations about a matter dealt with in the report or a decision letter at the end of:

- an investigation appeal
- a local resolution appeal
- an appeal following a disapplied complaint
- a supervised investigation
- a managed investigation
- an independent investigation

All recommendations made under this power will be published on our website. The recipient of the recommendation is required to provide a response within 56 days, which will also be published on our website. We cannot require organisations to implement our recommendations but they must provide a rationale if they do not. This will help us and others such as HMIC, Police and Crime Commissioners (PCCs) and the Home Office, to monitor actions against the recommendations which have been made and identify any issues that have arisen following recommendations which have not been implemented.

The recommendations we make using this power will help to improve the way organisations carry out their functions and/or the services they deliver, both by highlighting learning directly to the force or organisation involved, and by making this publicly available and accessible for other forces or organisations to learn from.

We have produced guidance for operational staff on making recommendations to police forces and other relevant organisations which are informed by best practice and take into account related recommendations made by us or by others.

We continue to draw the attention of PCCs, ministers and the public to cases where we feel responses to our recommendations are insufficient. We have also introduced a force liaison model to ensure that IPCC staff and commissioners are fully briefed and able to raise concerns with PCCs where there has been no response to recommendations.

We meet regularly with the chief coroner and, where appropriate, with coroners on individual cases to make sure that any issues are identified and addressed at an early stage.

Case study

Following an appeal by a man who complained to a force that he had been interviewed, charged and bailed in relation to an offence he was not arrested for we made the following recommendation:

That the force should issue clear advice to all custody officers on the importance of clearly establishing and recording the offence for which a detainee is held in custody. If the detention is declined /refused, it would be appropriate for a new custody record to be opened in the event of a further arrest for a different offence.

The force has accepted the recommendation and will disseminate it to all custody staff across the force.

It is also important that our recommendations, where they reflect general or national issues, can be fed into the training and standard-setting that is carried out by the College of Policing.

To formalise our existing links with HMIC and the College of Policing we agreed a concordat in relation to the promotion of good practice and continuous improvement in policing, in order to ensure public confidence. This agreement commits the three organisations to work constructively and effectively together by:

- regularly consulting one another on areas of mutual interest
- sharing information and analysis as appropriate to encourage timely, well-informed decision-making, and to assist the planning and prioritisation of work
- making sure the data collection and inspection regimes for police forces minimises unnecessary bureaucracy
- promoting clarity over roles and responsibilities
- developing efficient working relationships between the three organisations

Case study

We submitted a response to a College of Policing consultation on the revision of its Authorised Professional Practice on Detention and Custody. Our response focused on the learning from our investigations. In particular we highlighted that:

- *An assessment of vulnerability should inform the initial response and all further actions of the police, including decisions about use of force and whether an incident should be dealt with as a medical emergency.*
- *For those working in the custody environment, training is a vital part of making sure they are aware of the tasks they need to complete and the risks they need to be aware of.*
- *Once a risk assessment has been carried out and checks or rousing may have been put in place, it is essential that these are carried out at the frequency and standard expected.*
- *When risks are identified for an individual, this information needs to be provided to onward custodial providers.*
- *The IPCC strongly supports the recording of any use of force by the police.*

We will continue to work with the College of Policing to make sure that learning is reflected in the Authorised Professional Practice for Detention and Custody.

We are carrying out a study into the use of restraint and force by police, which we plan to publish in autumn 2015. The overall aims of the study are to:

- develop an understanding of when and how force is used by police personnel by analysing the findings of IPCC investigations and appeals;
- consider the factors that influence definitions of reasonable and excessive force by drawing on the opinions, views and experiences of police personnel, members of the public, experts and other specialist interest groups;
- develop an evidence base to inform relevant recommendations relating to operational policies and training and to support future IPCC recommendations in this area;
- provide the IPCC with an opportunity to use learning from this study to influence the work of partner organisations; and
- contribute to the debate around whether there should be a comprehensive system for recording use of force across the police service.

Continuing work

All of our work is underpinned by knowledge and information. This includes gathering information from a range of sources, analysing it to draw conclusions, and sharing findings and recommendations with stakeholders and the public.

We have produced a new Knowledge and Information Strategy to make sure that we are capturing, using and sharing all that we know as an organisation. The strategy will inform our corporate and business planning process to build our capability in this

key area. The strategy, once implemented, will help make sure that our learning recommendations are consistent and informed by best practice.

Better knowledge and information management will help us to:

- understand and identify the common factors that underpin serious and sensitive cases;
- identify underpinning trends in performance;
- prioritise stakeholder engagement in the right areas and inform our oversight and confidence work;
- improve operational decision making, and reduce waste and re-work caused by poor or difficult to access information; and
- inform and focus quality assurance activities.

4. Building the new IPCC

The remaining actions from our review of cases involving a death and the Rigg review can be found in Annex 1. The majority of these actions are being implemented through our change programme.

This year we have recruited additional operational staff and opened a new office in Birmingham. We plan to open a second new office by the summer 2015 and we are also expanding our office in Wakefield so that it can accommodate more staff.

In becoming the new IPCC we will conduct significantly more independent investigations and we will embed quality and customer service into everything we do. We are not just planning to take on more work in the same way, but to use this as an opportunity to reshape the way we carry out our work and to reinforce our independence and our values. We are currently developing our target operating model to enable us to effectively carry out a great deal more investigations. This work is expected to be complete by April 2017 and this date is therefore reflected in the timescale for some of our remaining actions to be fully in place.

We know that our change programme has raised expectations with some of our key stakeholders. We must meet this challenge and deliver. This is vital for our success and reputation with families, community and voluntary organisations, local leaders, police and politicians.

5. Conclusion and next steps

The remaining actions we have to implement will continue to be delivered through our change programme. The Commission will monitor the implementation of the remaining actions through our business planning process. Any significant developments will be reported in our future annual reports.

Annex 1 – Remaining actions

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised timetable
Independence					
3	We are planning to expand our training programme for all staff to include training on identifying and challenging personal bias.		Director of Resources	Mar-15	Mar-16
Scope and remit					
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.		Director of Strategy & Impact	Oct-14	Apr-15
Initial steps in assessment and investigation					
8	We will publish the criteria that we consider when we make a decision about how a case should be investigated.		Chief Operating Officer	Sep-14	Apr-16

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised timetable
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.	We will produce a clear statement setting out our expectations in relation to post incident management. This will also be informed by feedback from the IPCC's review of cases involving a death. This will include the need for officers to provide their individual accounts before communicating with each other about events when a death in custody is referred. This will be discussed with ACPO, disseminated to the police service and made public via our website (action 2).	Director of Strategy & Impact	Consultation begins March14	Summer 15
13	Additional resources will allow us to open more offices and increase our geographic coverage.		Director of Resources	Dec-14	Summer 15
14	As part of our change programme and our work on the development of a new operating model, we will review our on-call system, and consider how best to obtain specialised scene of crime expertise.		Chief Operating Officer	Apr-15	New on-call system Apr-15 Scene expertise – complete (specialists called in as required e.g. ballistics, forensics)

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised timetable
15	We will explore with the Association of Chief Police Officers (ACPO) the possibility of filming the process of scene preservation to make sure that evidence is secured and public confidence is maintained.		Chief Operating Officer	Oct-14	Summer 15
Conducting the investigation					
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.		Chief Operating Officer	Oct-14	Apr-15
23	We will revise our guidance to police on dealing with discrimination allegations.		Director of Strategy & Impact	May-15	Summer 15
26	We will reflect the actions and principles in this report and Dr Casale's review in our new operating model. The new model will make our structures and processes more flexible and support timeliness and quality assurance. This will include external review.		Chief Operating Officer	Dec-14	Apr-17
27	Once the new operating model is in place, we will publish a revised operations manual so that our practices can be understood and scrutinised.		Chief Operating Officer	Apr-17	n/a

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised timetable
28	As part of our new operating model, we will make sure that we effectively use specialist expertise, both internally and through external support in areas such as forensics, mental health and discrimination.	We are currently looking at our use of experts in investigations and will consider this recommendation as part of this work (action 24).	Chief Operating Officer	Apr-15	Apr-17
Engagement during investigations					
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.	We are further reviewing the way we work with families in the context of our review of cases involving a death. This will include establishing and sharing best practice in family engagement (action 21).	Chief Operating Officer	Apr-15	Apr-17
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.		Director of Strategy & Impact	Sep-14	Apr-16
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.		Director of Strategy & Impact	Sep-14	Apr-16

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised timetable
47	As we grow and develop, we will review all of our communications strategy, to help us make sure that we can communicate our work, role and outcomes more effectively.		Director of Strategy & Impact	Mar-15	Apr-16
Reporting, outcomes and learning					
48	We will put in place 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.	We currently have a working group which is looking at investigation reports and this recommendation will feed in to the considerations of that working group (action 28).	Director of Strategy & Impact	Apr-14	Summer-15
49	As part of our change programme, we will consider creating an enhanced editorial function to make sure our reports are clearly written.		Director of Strategy & Impact	Mar-15	Summer 15
52	We will publish the outcomes of our investigations, making clear our own outcomes and those that result from disciplinary or criminal processes.		Director of Strategy & Impact	From May-14	Summer 15

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised 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 make sure full and timely disclosure.		Chief Operating Officer	Dec-14	Apr-17
56	We will 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 make clear our role in inquests.		Chief Operating Officer	Mar-15	Dec-15
58	As part of the change programme, we will develop systems and support and train staff to make sure 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.		Director of Strategy & Impact	Mar-15	Apr-17
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.	Restraint is a key priority for us and we are currently looking into when resources can be released to carry out some more in-depth work to explore restraint related issues (action 34).	Director of Strategy & Impact	Mar-15	Autumn 15

Ref	DEATHS REVIEW ACTION	RIGG REVIEW ACTION	SRO	Original timetable	Revised timetable
Rigg review additional actions					
74		We will examine the way we use information for analytical purposes and develop systems to support our oversight and confidence work (action 41).	Director of Strategy & Impact	Ongoing	Apr-16

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