Deaths during or following police contact annual report

User engagement feedback

Last updated: January 2018

Contents

For copies of the annual death report and other studies, please visit the IOPC website at www.policeconduct.gov.uk.

This is a working document and will be updated periodically when feedback has been received and processed

1. Introduction

The information presented in the annual report is a valuable source of data. It can help to inform debates and support essential discussions between police forces and other stakeholders to share learning and/or review policies and practices towards preventing further deaths in or following police contact where possible.

This document details the feedback received on the annual death report and how it has influenced the information in the report or the data collection process. This document will be updated with future feedback, our response and impact.

For information on our user engagement strategy, please see the policies and statements document.

Becoming the Independent Officer for Police Conduct (IOPC)

On 8 January 2018, the IPCC became the IOPC, as set out in the Policing and Crime Act 2017. The Act introduces several changes that we asked for – both to the police complaints system and to the structure and powers of the IPCC.

Since 2013, we have doubled in size and are taking on nearly six times as many independent investigations. Given this level of growth, we asked the Government for a new structure that is better suited to our much expanded organisation. The new structure will have a Director General at its head, supported by two deputies, and a network of regional directors and a director for Wales. As it will no longer be a 'commission', we are taking on a new name.

It's important to note that while our name will change, our role, purpose and independence will not. The IOPC will continue to oversee the complaints system as a whole, to provide an independent appeal mechanism for some complaint investigations carried out by the police, and to carry out our own independent investigations into serious and sensitive cases. We will continue to use what we learn through our work to improve policing.

Reference to the IOPC in this document, also covers the processes and policies that were in practice when we were operating under the name IPCC from 1 April 2004 to 7 January 2018.

2. Users and uses

The annual death report is available on the IOPC website and is therefore open to many potential users. Key users of the report include:

- Police forces
- National Police Chiefs' Council (NPCC)
- Association of Police and Crime Commissioners (APCC)
- Police Crime Commissioners (PCC)
- College of Policing
- Home Office
- Her Majesty's Inspectorate of Constabulary (HMIC)

- Her Majesty's Inspectorate of Prisons (HMIP)
- Independent Advisory Panel (IAP) on deaths in custody
- Interest groups such as Inquest, Institute for Race Relations, Coroners Society, Independent Custody Visitors Association and Crown Prosecution Service

Internally at the IOPC, the key users of the report and the statistics include the Director General, Regional Directors and the Director of Wales, Investigations, Policy and Press, and when operating as the IPCC included the Chair, CEO and Commissioners.

The report provides data and information on a highly sensitive topic area. It is used to promote and inform debates and discussions among police forces and other stakeholders and interested parties. It provides users with an opportunity to learn from the cases that appear in the report and identify, take action and/or review policy to help prevent such deaths from happening again where possible.

The findings in the report are a good source of data to be used as a basis for discussing and supporting other research. For example, the high prevalence of mental health amongst deaths of those in custody prompted the IPCC's research on the use of police custody as a place of safety under S.136 of the Mental Health Act.

Another study that developed from the findings of the annual death report went on to examine in detail fatal and serious injury cases following a road traffic incident involving the police. Following this research report, the IPCC worked closely with the then Association of Chief Police Officers (ACPO)[1] to improve policy and practice in this area. Pursuit management guidelines for police forces were developed that have the force of law. These are now owned by the College of Policing as Authorised Professional Practice on police pursuit.

The figures are also used in the IAP's report that presents figures on all deaths of individuals detained in state custody. The circumstances of relevant deaths will also be reviewed as part of the IPCC's study of police use of force that is due to report in late 2015.

3. National Statistician's review

The figures produced in the annual death report received public criticism at the beginning of 2012. At the request of the CEO, a formal independent statistical review was conducted by the National Statistician into the collation, analysis and presentation of the IPCC's annual death statistics and death in custody study. Read the terms of reference.

Following the two-month review, the National Statistician concluded that the figures "are collated conscientiously with a consistent process that is followed routinely" and "that the criticisms made about the publications…are unsupported".

A copy of the full report can be found here. It made five recommendations which the IPCC responded to and which were published in the 2011/12 annual death report. These are;

1. *Recommendation*: Make clear from the outset where future research studies are one off publications and how they relate to the regular statistical publications.

[1] ACPO has now been replaced by the National Police Chiefs' Council (NPCC).

Response: We have ensured that an explanatory commentary regarding the nature and content of the report is given prominence in order to avoid any potential misinterpretation by users.

2. *Recommendation:* Provide users with more information on the process for compiling the statistics – to improve trust in the statistics and how they are produced.

   Response: We have produced a stand-alone guidance document, which provides additional detailed information on how the IPCC and now the IOPC collates and categorises deaths for inclusion in the annual report. This is available on the IOPC website.

3. *Recommendation:* Consider including in the annual statistics more detail on cause of death, including figures for secondary cause of death.

   Response: We have reviewed how we report on cause of death and where applicable, have included information on secondary cause of death.

4. *Recommendation:* Consider putting the annual statistics forward for an assessment by the UK Statistics Authority against the Code of Practice for Official Statistics.

   Response: The annual death report was assessed by the UK Statistics Authority and in July 2013 the Assessment Committee approved its designation as National Statistics for the 2012/13 report and all subsequent releases.

5. *Recommendation:* The research team should also further develop its working relationship with the Home Office Head of Profession for Statistics, whilst being mindful of the IPCC, and now the IOPC's, independence from the Home Office.

   Response: This process has already been initiated and we intend the relationship to be established further in the future in order to help safeguard the professional integrity of the statistics.

4. IPCC Death review

In March 2014, the IPCC published the findings from its review into its work in cases involving a death. The purpose of this review was to engage with all of those who have experience of our work investigating deaths, including our critics, to increase public confidence in this important area of our work. Alongside the findings we published an action plan. The actions included delivering changes in approach and procedure, including ensuring effective engagement with families. The IPCC published an update report in March 2015 which provides a summary of the progress made against the action plan detailed in the final report.

- No specific feedback was received relating to the compilation of, or the way the information is presented in the annual death report from this review.

5. General feedback and observations

- Over the years, interest in, and the use of Tasers by the police has increased. For this reason, since 2012/13 we have routinely collected information on the use of Taser, CS Spray and the use of restraint equipment for the cases included in the annual death report.

This has increased the breadth of information we hold and assists us in responding to queries. We are currently collecting equivalent data retrospectively for deaths that occurred prior to 2012/13.

- Following feedback from a coroner on how cause of death was reported in the annual death report, we reviewed our approach to reporting on this. We now include, where known, the cause of death using the wording detailed in the pathologist's report following post mortem. The change has improved the detail and accuracy with which this information is presented.

6. Annual report feedback questionnaire

In order to gather feedback on the annual report, users have the option of completing a feedback questionnaire that is hosted on the IOPC website next to the link to the annual report. It is intended that data collected would be analysed periodically and summarised below, together with our response to the feedback. The survey went live in July 2013; we have not yet received any feedback via this survey.

7. Contact details

All of the annual death reports are free and available to download from the IOPC website in a PDF format. If you have any questions or comments regarding the annual death report you can contact the Research Team directly on research@policeconduct.gov.uk.

Alternatively and for all other IPCC enquiries, contact the switchboard helpdesk on 0300 020 0096, or enquiries@policeconduct.gov.uk, or see other contact methods.