ipcc
independent
police complaints
commission

Referrals from Metropolitan Police Service Relating to Fatalities April 2004 – December 2008

To include: Fatal Police Shootings, Deaths in Road Traffic Collisions, Deaths in or Following Police Custody and Deaths Following Police Contact

April 2009

Aim

The aim is to provide an overview of deaths from police shootings, road traffic collisions, following police contact and in custody in the Metropolitan Police Service in order to identify and analyse the outcomes of investigations, and to enable a better understanding of the learning that has been obtained from these cases.

Scope

The scope of the research and analysis conducted is as follows:

- The period analysed is 1 April 2004 to 31 December 2008;
- The data collection includes all deaths referred to the IPCC in relation to the four categories above by the Metropolitan Police Service during this time;
- The analysis focuses on the outcomes of independent, managed and supervised investigations;
- The case list has been produced by the research department from cases previously agreed and validated by the MPS. Cases since Jan 2008 have not yet been validated by the MPS.

Limitations

The completion of this report was hampered by the fullness of data set. The report consists of data between April 2004 and December 2008 and therefore does not include the full data for the financial year 2008/09. Time constraints prevented full data for this year being utilised, preventing full analysis of year on year data.

Overview

Over the period from April 2004 to December 2008 there have been 76 deaths referred to the IPCC. These related to:

- 9 fatal police shootings
- 25 fatal road traffic collisions
- 24 deaths in or following custody
- 18 deaths following police contact.

These deaths have resulted from 72 incidents (four incidents each resulted in two fatalities). The incidents are split fairly evenly through the period with 14 in 2004/05, 18 in 2005/06, 12 in 2006/07 and 12 in 2007/08. The 2008/09 figure of 16 referrals relates to nine months worth of data and therefore not comparative, but it is of note due to the relatively high number received.

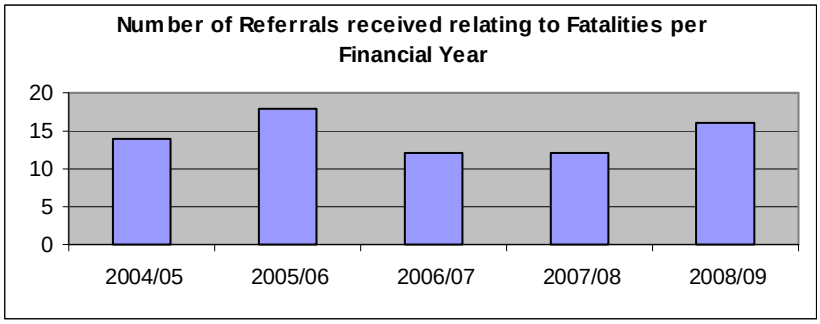

Figure 1: The number of deaths referred by the MPS to the IPCC per year.

The vast majority of these referrals resulted in an assessment by the IPCC to determine the mode of investigation (MOI). Assessments are carried out to inform the appropriate level of IPCC involvement, for example to consider whether Article 2 of the European Convention on Human Rights (right to life) is engaged. In some cases, such as fatal police shootings, it is clear from the outset that Article 2 is engaged and assessment is not necessary. In other cases it is clear following assessment that there is no connection between the police contact and the subsequent death and the investigation is referred back for local handling.

In response to the referrals, the IPCC carried out:

- 26 independent investigations
- 22 managed investigations
- 5 supervised investigations
- 19 being referred back for local investigation

Between 2004/05 and 2007/08, the percentage of referrals from the Metropolitan Police that have been investigated independently by the IPCC has increased year on year. In the first year 2004/05, 14% were independently investigated, 33% in 2005/06, 38% in 2006/07 and 55% in 2007/08. Until December 2008, the percentage of referrals investigated independently in 2008/09 was 50%. In contrast to this the number of supervised investigations has decreased, with none in the last three years. This recognises an increasing ability by the IPCC to undertake independent investigations, as well as

developments in case law around Article 2 of the European Convention on Human Rights requiring independent investigations.

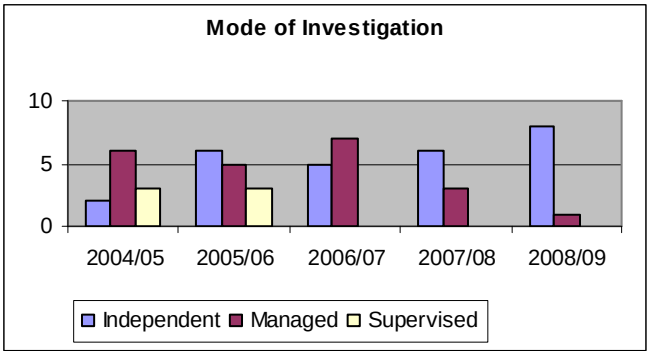

Figure 2: The Mode of Investigation by year

Geographic Analysis

Figure 3. Map of referrals from MPS relating to fatalities by borough (Original map template taken from http://www.yourlondon.gov.uk/jobs/index.jsp)

A. City of London	**G. Lewisham**	**M. Hammersmith and Fulham**
B. Tower Hamlets	**H. Lambeth**	**N. Richmond**
C. Southwark	**I. Camden**	**O. Kingston**
D. Westminster	**J. Islington**	**P. Waltham Forest**
E. Kensington and Chelsea	**K. Hackney**	**Q. Barking and Dagenham**
F. Newham	**L. Wandsworth**	

Figure three illustrates the breakdown of boroughs where the deaths have occurred. This highlights the boroughs of Lambeth and Greenwich as having six and five deaths respectively in the reporting period.

Of the six deaths in Lambeth borough, three were in or after custody. One was a death following police contact, one was from a road traffic collision and one was a fatal shooting. Three of the investigations were independent, two were managed and one was carried out

locally due to no causal link being made between the police contact and death.

Of the deaths in Greenwich, one was from a road traffic collision, two were in or after custody and two were during or after police contact. Three of these deaths were investigated independently whilst the other two were managed.

Drugs / Alcohol

Over the reporting period 28 (39% of sample) of the deaths have been identified as having drugs or alcohol as a factor. These can be broken down into four road traffic collisions, 16 in or after custody, eight during or after police contact and one shooting. 11 of the incidents related to alcohol as a factor, 14 to drugs and three to both. Of the drug related deaths, nine were following the deceased concealing drugs in their mouths or swallowing them.

There appear to be common threads within investigations with a factor of drugs/alcohol, of organisational recommendations relating to transport to the hospital / handover to London Ambulance Service (LAS), use of CAD and CCTV in custody suites.

Four investigations have recommendations around transport to hospital/ handover to LAS. The recommendations included:

- MPS review their policies on the transportation of a detained person with a view to providing guidance to officers on what options can be taken when a medical emergency or difficulty arises during the journey;
- A joint LAS and MPS review take place into the handover of persons from one agency to another with a view to establishing a Standard Operating Procedure which provides for a documentary handover comprising a certification of police fitness to detain.

Two investigations, completed in August 2007 and October 2007, recommended that a review of audio and CCTV products should be undertaken of all MPS Custody installations to ensure that the audio product available fully meets requirements and is sufficiently clear to enable effective transcription to review locations of CCTV cameras, and to consider the use of microphones to accompany CCTV.

National recommendations related to learning being passed to the ACPO lead on Officer Safety Training around risk assessments including a specific section about cocaine intoxication and the issue of detainees swallowing packages.

Mental Health

A total of eleven deaths had a contributing factor of mental health, of these five were in or after custody, four were during or after contact and two were shootings. These cases may indicate a training issue around the treatment of arrestees who have mental health issues. Eight of these eleven deaths were in the last two years.

Extensive research has been conducted on mental health and police custody, the IPCC has published research on the detention of individuals with mental health issues, this is available at: http://www.ipcc.gov.uk/index/resources/research/mh_polcustody.htm.

Investigation Outcomes

The 72 referrals resulted in 53 investigations with IPCC involvement, of which 44 had been concluded when this report was being written. Figure 4 indicates the outcome of these.

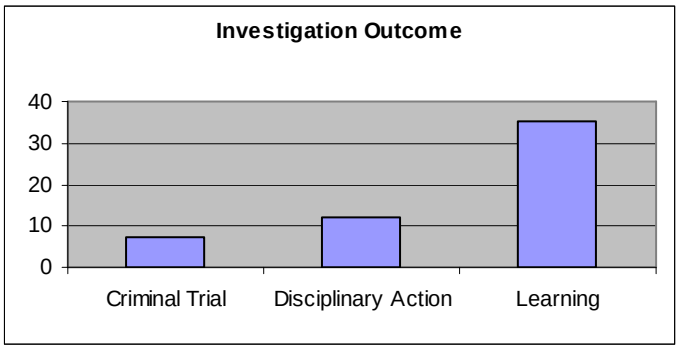

Figure 4: Investigation outcomes by Criminal Trial, Disciplinary Action and Learning

Of the 44 completed investigations, seven investigations resulted in eight criminal charges:

- 1 for Misconduct in Public Office in relation to a death in custody, where the defendant police employee was sentenced to 6 months' imprisonment;
- 2 for death by dangerous driving
- 4 in relation to driving without due care and attention
- 1 for breach of Health and Safety legislation.

Of the death by dangerous driving charges, one is yet to go to trial, one was tried and the officer acquitted. The driving without due care and attention trials led to one officer being found not guilty, one being found guilty, one case was dismissed and the final case which involved two officers; one pleaded guilty and was given an absolute discharge, the other pleaded not guilty and was found to have no case to answer. The Health & Safety Trial resulted in the Office of the Commissioner of the Metropolis being found guilty and fined.

In terms of disciplinary action, four investigations have led to written warnings for a total of eight officers and one is awaiting formal misconduct proceedings for three officers. Ten investigations have resulted in 14 officers and three police staff receiving words of advice.

Of the 44 investigations with IPCC oversight which have reached the report stage, 36 investigations have made recommendations, emanating from 15 independent investigations, 18 managed investigations and three supervised. 16 investigations had recommendations on an individual level, 27 on an organisational level and eight on a national level. The common themes through the recommendations were around crossover between police and medical practitioners, use of CAD, CCTV and awareness of domestic violence.

Analysis – Fatal Police Shootings

Nature of Investigation

There have been nine fatal police shootings in eight cases in the reporting period. These are spread fairly evenly through the period, with one or two incidents each year. They have all been investigated independently by the IPCC.

Investigation Outcomes

Only two of the investigations have yet been before an inquest, resulting in one lawful killing and one open/ narrative verdict. Two investigations are not concluded. Of the concluded investigations, three investigations have made learning recommendations. As for all IPCC investigations into police shootings, the recommendations that resulted have been referred to the national ACPO working group on police use of firearms.

Analysis – Deaths in Road traffic Collisions

Nature of Investigation

Over the period of the analysis 25 deaths resulting from an RTC were referred to the IPCC. There were 22 collisions in total as three incidents resulted in two fatalities each. Of these one has been investigated independently, 11 were managed investigations, two were supervised investigations and eight were referred back for local investigation after the IPCC had carried out an assessment. Figure 5 shows the number of RTC fatalities by MOI.

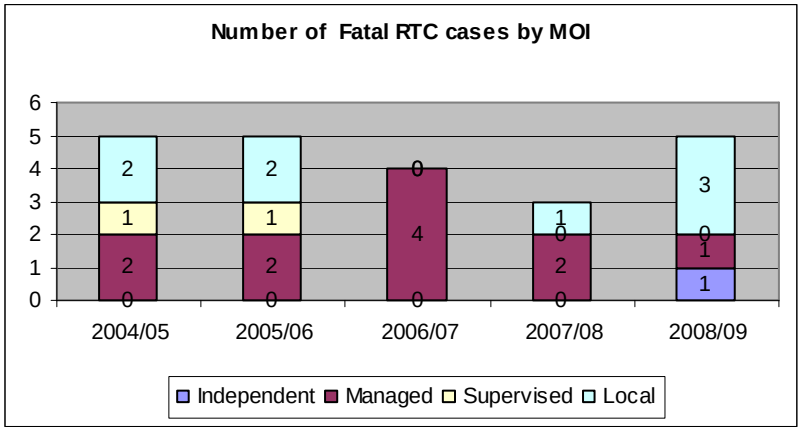

Figure 5: The number of Fatal RTC cases each year by mode of investigation.

Eight of the deceased were pedestrians. Seven died while crossing roads, one died after a police vehicle lost control and mounted the pavement.

Of the deceased four were passengers; two involved pursuits following Automatic Number Plate Recognition activations (in different incidents), one was a passenger in a car hit by a

pursued vehicle and the fourth was the passenger of a vehicle pursued by police. There were six solo motorcyclists (one moped) involved in an RTC following pursuits. Seven were drivers; of which six were drivers of pursued vehicles and one was the driver of an unrelated vehicle.

Geographic Analysis

The borough with the highest number of fatalities is Barking & Dagenham with three collisions followed by Enfield, Redbridge and Tower Hamlets with two each. It appears that the boroughs with the highest numbers of fatalities are all in outer London. Larger and more crowded inner London boroughs such as Southwark, Camden and Islington have had no fatal collisions since 2004.

Investigation Outcomes

Of the concluded investigations, 5 investigations have led to 6 criminal proceedings, of which one is pending. Of the remaining, two officers were found guilty and three were found not guilty. None received a custodial sentence. One officer received a written warning and one words of advice and response driver training.

An investigation in 2004 recommended a review of the decision to reduce the MPS driving course length, supervision of new drivers for a length of time and highlights as a factor the propensity to train young drivers rather than more experienced officers.

The IPCC's 2007 study of Police Road Traffic Incidents recommended that "ACPO should revise its guidelines to state that pursuits of motorcycles or other 'powered two-wheel vehicles' should not occur unless a serious crime has been committed. Where it is necessary for reasons of public safety to conduct pursuits of these vehicles, police force helicopters should be deployed at the earliest opportunity to take over the pursuit." The MPS policy embraces the ACPO guidelines and is overseen by the Central Control Rooms who have authority to permit or curtail pursuits. Questions have however still arisen about the implementation of this policy.

Analysis – Deaths in or Following Police Custody

Nature of Investigation

During the reporting period there have been 24 referrals made by the MPS in relation to deaths in or following police custody. In 8 of the 24 cases the detainee was not in a custody suite at all, but any death following arrest is still categorised as a death in custody.

Twelve of the referrals were/are being independently investigated; six were managed investigations; two were investigations supervised by the IPCC; and four were referred back for local investigation. Figure 6 indicates the mode of investigation for the referrals received each year.

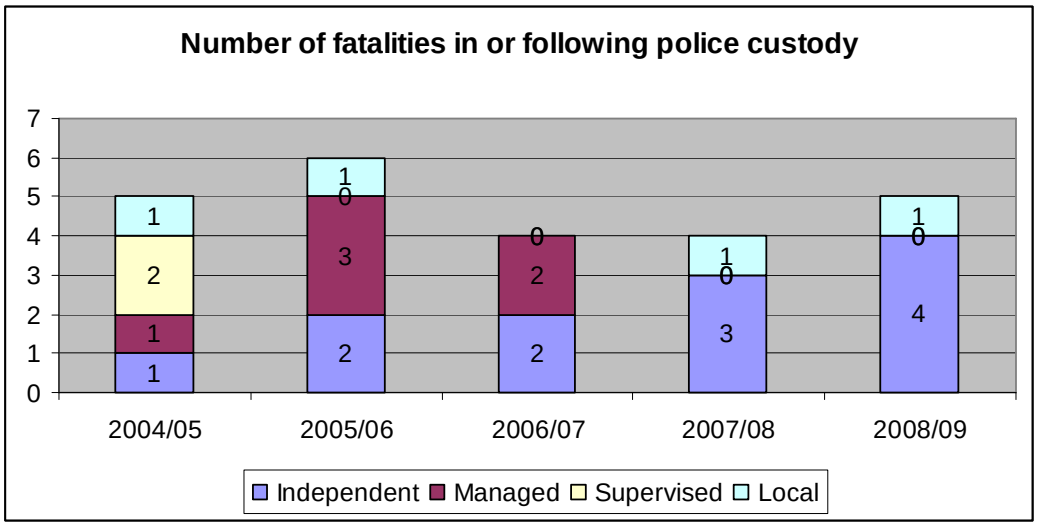

Figure 6: The number of fatalities in or following police custody for each year by MOI.

The main themes in these cases are as follows:

Swallowed a package during police intervention

Five cases relate to the swallowing of packages containing drugs at or around the point of police intervention. The deaths of these individuals were attributed at post-mortem to a number of similar factors relating to either the ingestion (or failed ingestion) of drugs packages, e.g. acute cocaine toxicity.

There have not been any deaths in the MPS area relating to the ingestion of drugs during police intervention since March 2008. It is possible that the reviews and operational advice given around this area by the MPS has had a positive impact, although it is too early to draw firm conclusions.

Drugs/Alcohol-Related Death

Ten cases correlate directly to Drugs/Alcohol related deaths (these differ from the 'swallowed packages' insofar as the ingestion happened prior to contact with the police, and the deaths are more directly linked to the effects of the substances).

The reasons for arrest in these cases differ from the 'swallowed packages' as only one arrest was made for drug-related offences. The reasons for arrest in these cases are similar, encompassing public order offences, breach of the peace, domestic assault ABH, assault, and one of the deceased was detained under the Mental Health Act rather than arrested. In all of the cases the behaviour of the individuals made them conspicuous to the police. In all except two of the cases the deceased was behaving in an aggressive manner either in domestic situations or similar.

Excited delirium is mentioned in the reports of two cases, and is considered a possibility for a third case which is not yet at the final report stage. This reinforces the need to highlight excited delirium in the drugs training given to MPS officers.

Pre-existing Condition

Three of these cases were independently investigated, two managed, and two locally investigated. The reason for the arrests in these cases relate to the deceased having been arrested for public order offences, driving offences, racially aggravated disorder and one in relation to a domestic violence incident.

In three of the cases the detainee collapsed in the cell, and was taken to hospital following first aid being given in the custody suite. In one case the FME directed the detainee to be taken to hospital owing to his pre-existing injuries. In one case, the deceased was found slumped at the wheel of a vehicle following an RTC and was arrested for driving offences. The deceased's pre-existing medical condition (which likely led to the RTC) was initially mistaken for intoxication, and this situation was exacerbated by language difficulties.

Suicide

From the referrals made to the IPCC, it is noticeable that there has been just one death in or following custody relating to suicide. This case relates to a woman who was arrested for assault following a domestic call out. On the advice of the FME she was moved to a camera cell and made subject to fifteen minute checks, but she was later found to have self-strangulated using a scarf which had previously been taken from her and placed outside her cell, but was placed inside her new cell when she was transferred.

It was noted in the report that Custody Officers must have specific reason for considering that a detained person might self-harm to remove items from them, rather than considering the potential use of an item to self-harm (Grange v CC West Yorks Police 2001). It was also noted that it had become common practice for custody officers to remove items irrespective of the detainee's state of mind. At the inquest, the coroner stated that she hoped that common sense over this issue would prevail.

Other Contributory factors

Vehicle Stops

Five of the 24 deaths followed on from vehicle stops, and the occupants of the vehicles were arrested for drug possession, suspicion of possession, drink-driving, being unfit to drive and dangerous driving. One took place in each of Lewisham, Kensington and Chelsea, Bexley, Havering and Islington.

Mental Health

It has been documented that around 50% of all deaths in or following police custody involve detainees with some form of mental health problem, but for 2007/08 three of the four deaths in this category had a factor of mental health. In all three of these cases the detainee resisted officers' attempts to arrest/detain, and in one case it was noted by the pathologist that the struggle with the officers was a contributing factor to his death. In two of these cases the deceased had taken cocaine, and in the other the deceased had consumed alcohol.

Interaction with LAS

There were three custody cases during which issues around the interaction with the LAS were raised. These issues were around the non-arrival of ambulances and the grading/computerised call-outs of ambulances failing; a need to establish an SOP which provides for a documentary handover comprising a certification of police fitness to detain; the need for a review of London Ambulance Service and Metropolitan Police Service co-operation and information exchange; and the need for officers to give a full appraisal to LAS staff when handing over a detainee/patient.

There was a spate of three 'Swallowed Package' deaths in the first three months of 2007, which brought about a review in the DPS of the training for such incidents.

Geographic Analysis

Boroughs in south-west London had the highest numbers of deaths in or following custody in the reporting period, including three in Lambeth, two each in Lewisham and Greenwich, and one each in their bordering boroughs of Bromley and Bexley. Of the four Lewisham and Greenwich deaths in custody, the Lewisham deaths both related to swallowing of packages following incidents of proactive policing and both occurred in March 2007.

Investigation Outcomes

In relation to the investigation outcomes, six of the 24 cases have not yet reached a conclusion. In one case a Dedicated Detention Officer was found guilty of misconduct in public office and jailed for six months. Disciplinary outcomes were noted ranging from formal misconduct proceedings against an Inspector and two Sergeants to words of advice around matters of custody record keeping and handover procedures.

Other Considerations

It is noteworthy that there appears to have been only one suicide in MPS custody in the last four years. In the IPCC's Near Misses Report published in March 2008, 56 near misses (throughout the MPS) from May 2005 to April 2006 which involved self harm/suicide were identified, 36 of which involved self-strangulation. The report also states that in the opinion of the researchers the aversion of fatalities owed much more to the correct following of procedure than any sort of serendipity. This low figure for suicide fatalities in custody should be commended.

In the cases where members of the public have swallowed drugs packages to avoid arrest, the choice to swallow the package is clearly that of the individual, but a warning highlighting the risks to individuals when they choose to swallow packages at the point of arrest could be proffered to a relevant audience (i.e. those who have been charged with drugs obstruction, and/or those with repeated and increasing levels of drugs possession charges).

Analysis – Deaths Following Police Contact

This category of cases involves deaths that have followed police contact, where there is or may be some causal link between the contact and the death.

Nature of Investigation

During the reporting period there have been 18 referrals for deaths following police contact in the MPS. Six of these referrals have been investigated independently, five of which are concluded. All five of the closed investigations have provided recommendations for the organisation. Five investigations were managed.

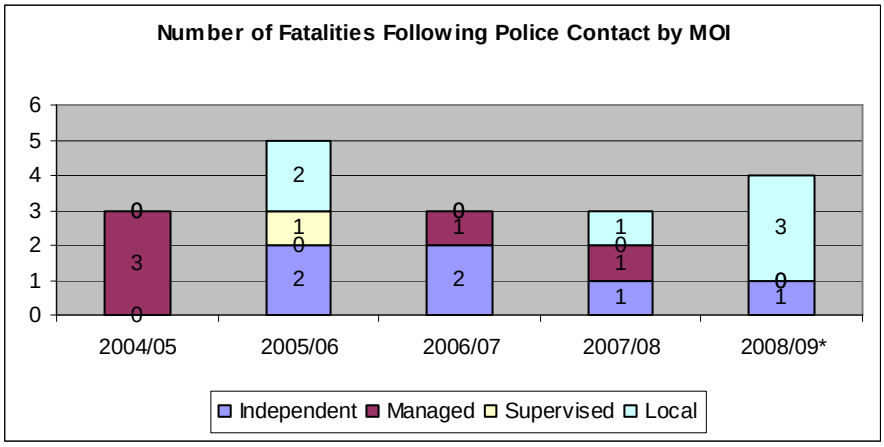

Figure 7: The number of fatalities following police contact for each year by MOI.

Seven deaths are linked to the deceased being involved in a fall, five of whom fell from a window or balcony after officers entered the building.

The initial contact in 6 of the 18 cases was domestic violence related, four of which involved alcohol/drugs. Of these four, three involved the deceased inflicting self harm.

Cases in this category also include allegations of a police failure to protect, resulting in loss of life. Most of these have arisen in the domestic violence context, and have resulted in recommendations around improvements in the police response to domestic violence.

Investigation Outcomes

Four officers have received written warnings; two officers have been recommended to receive further training, and eight officers and two members of police staff have been given words of advice.

One of the investigations that had individual recommendations for CAD controllers also had a recommendation to review CAD training, and ensure that there is post-training examinations and continual on-the-job training. Another investigation had an organisational recommendation to ensure that open CADs are frequently reviewed and that R graded calls are no longer used, and instead a call is to be graded on the incident and urgency (steps have been taken to implement this).

Two of the investigations have organisational learning recommendations in relation to the handling of domestic violence, both relate to police standard operating procedures in this area.

Learning the lessons: developments

This report analyses nearly five years of referrals of fatalities from the Metropolitan Police Service, most of which resulted in some form of recommendations for the police. The process of evaluating recommendations and ensuring learning has evolved significantly over that period. “Learning the lessons” is a national initiative for the IPCC, with a programme managed by a multi-agency Learning the Lessons Committee made up of IPCC, APA, HMIC, Home Office and ACPO, responsible for disseminating significant learning from investigations to police forces. The Committee has published six Learning the Lessons Bulletins since June 2007, and aims to publish three per year.

At a local level, a new framework was implemented to capture learning from managed and independent investigations, from October 2007. The project includes the following elements:

- Terms of reference which emphasise potential learning as a priority of the investigation;
- “Learning reports” now included as a separate section of investigation reports;
- A process of validation of recommendations, at both the local and national level;
- Dissemination of recommendations through the Learning the Lessons Bulletin.

ACPO is currently establishing a system for collection of learning from local and supervised investigations, so that significant learning at this level can also be included in the bulletin.

This multi-agency approach assumes that police authorities, in their oversight role, have the primary responsibility for following up learning by assessing the risks their force faces and whether resources are adequate to deal with them, and monitoring the force's performance in the areas highlighted. Further work is however required to ensure that procedures are in place to support this role.

MPS Response

The IPCC note the creation within the MPS in 2005 of a specific unit, the "prevention and reduction team" to draw together the learning from investigations, inquests, near misses and complaints. The work of that unit directly led to the introduction of defibrillators in all custody suites and front offices as well as a number of other safety related improvements. This unit is now engaged in learning the lessons work and raising awareness with officers through direct contact and training.