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Andrew Harris
HM Senior Coroner
London Inner South
Southwark Coroner's Court
1 Tennis Street
Southwark
SF1 1YD

Dear Sir

And by email to :
30 June 2022

Inquest touching on the death of lan Taylor Case Ref: 159801
Prevention of future death report

I write on behalf of the Director General of the IOPC with the first matter of concern raised in your Prevention of Future Death report arising from the inquest into the death of Mr Taylor, which concluded on 19 May 2022. This letter is the IOPC's formal response to your report in accordance with Regulation 29 of the Coroners (Investigations) Regulations 2013.

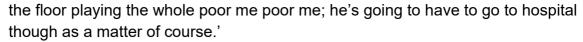
Matter of concern: the current fitness of to serve as a police officer

In your report you highlighted the following evidence heard in court from officers in person and the body worn footage (BWV):

- At 18.18hrs officers decided to move Mr Taylor to the police car where it was cooler. Mr Taylor was lying down and had to be assisted to stand. My Taylor told officers that he was going to die and asked them to help him stand up. reassured Mr Taylor that he was not doing to die and told the court that officers had to support Mr Taylor to walk to the car as he initially did not support his own weight.
 BWV captured Mr Taylor saying something like 'I'm fading' and 'I'm going to die now'.
- Shortly before the above interaction (at 18.14hrs) while was away from Mr Taylor he stated to his sergeant on the radio that '[Mr Taylor] was currently on

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- Shortly after the above interaction (at 18.24hrs) also stated to his sergeant on the radio that '[Mr Taylor was] saying he has chest pains he can't breathe blah blah; it's a load of nonsense but there we go'.
- In his evidence to the court denied that he thought Mr Taylor was faking illness and stated he formed the views (relayed to the Sergeant) as Mr Taylor seemed iller than he would expect from the nature of the previous altercation.
- He further gave evidence that his views were influenced by a previous incident in which a man sprang to violence from previous calmness.
- claimed to have made a continual risk assessment, but there was no record or evidence of this before the court.
- stated the views he expressed to his sergeant were not his final conclusion but there was no evidence suggesting he formed a different conclusion in the 8 minutes between his radio comments and Mr Taylor's cardiac arrest.
- did not acknowledge that he had learnt any lessons from the incident and, in response to questioning about whether he would do anything different in future, made excuses for his comments and said that he would be more sensitive in future.
- He did not accept that he had made an inadequate risk assessment or that such comments could have or might in future contribute to death by indicating a lack of urgency to a sergeant not at the scene.
- Although given an opportunity to make any other comment, and did not apologise to Mr Taylor's family.

In your report you also highlighted the level of the family's concern with regards to public safety arising from these matters.

In light of the above, you asked the IOPC to consider whether further investigations or reports are warranted to give reassurance to the public about the fitness of this officer to serve.

Action taken

In response to your report, I have considered whether the matters raised by the inquest with regards to would require any further handling under the Police Reform Act 2002.

Under this legislation, concerns about the conduct of a person serving with police may be recorded and referred (subject to meeting the relevant statutory criteria) to the IOPC for consideration whether an investigation is necessary, and if so, whether an independent investigation is required. Decisions to record and refer are usually made by the force with

whom the officer in question is serving (known as the appropriate authority). However, the IOPC can also require an appropriate authority to refer a matter or, in some circumstances, treat a matter as having been referred.

Conduct matters are defined in the legislation as any matter which is not and has not been the subject of a complaint where there is an indication that a person serving with the police may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings. Disciplinary proceedings are justified where the conduct, if proven, would justify a sanction of at least a written warning.

Conduct matters which must be referred to the IOPC are:

- matters which relate to any incident or circumstances in which (or in consequence of which) a person has died or suffered a serious injury;
- serious assaults;
- serious sexual offences;
- serious corruption;
- a criminal offence of behaviour liable to lead to disciplinary proceedings which was aggravated by discriminatory behaviour;
- a relevant offence;
- conduct alleged to have taken place in the same incident as one in which one or more of the foregoing types of conduct is alleged.

I have given careful consideration as to whether the matters reported in respect of

would meet the definition of a conduct matter described above.

The distress that comments to his Sergeant, and the lack of insight and reflection shown in his evidence to the inquest, will have caused to Mr Taylor's family, is a harm resulting from his behaviour which will also be capable of harming public confidence in the police service more widely. I agree that this behaviour does need appropriate intervention. Balanced against this, this appears to be a one off incident rather than a pattern of behaviour and while the inquest jury concluded that the dynamic risk assessment of the officers present was not adequate, the evidence did not suggest that comments to his Sergeant delayed or otherwise affected the treatment of Mr Taylor. Taking all these factors into account, I have concluded that the behaviour would not meet the threshold for justifying disciplinary proceedings for the purpose of being treated as a conduct matter under the 2002 Act.

The appropriate authority, the MPS, have informed the IOPC that they propose to refer to the reflective practice review process, a formal but non disciplinary process set out in Part 6 of the Police (Conduct) Regulations 2020. This process can be used where the appropriate authority has identified 'practice requiring improvement', defined as underperformance or conduct not amounting to misconduct justifying disciplinary

proceedings or gross misconduct, which falls short of the expectations of the public and the police service as set out in the Code of Ethics issued by the College of Policing.

I agree that this is an appropriate intervention. BWV capturing his comments at the time, and the record of his evidence to the inquest. A further investigation therefore does not appear to be necessary in order to establish the extent of his behaviour or test the evidence. Under the Police (Conduct) Regulations 2020, the appropriate authority has the power to refer an officer to the reflective practice review process without an investigation. The Home Office Guidance on Conduct, Efficiency and Effectiveness 2020 states that the reflective practice review process is intended to:

"involve accountability for actions and taking responsibility by individual officers and the organisation. The process is intended to provide an open and reflective environment to approach issues and mistakes that have arisen. There should therefore follow a greater willingness to discuss the facts at issue and a positive attitude about taking steps to put things right and improve for the future."

The reflective practice review process leads to a reflective review development report, which (among other things) must contain key actions to be undertaken within a specified time period, any lessons identified for the participating officer (and for the line management or police force concerned) and specify a period of time for reviewing the report and the actions taken.

I am satisfied that this process can be used effectively to prompt the reflection and insight into this incident lacking in testimony and lead to a recognition of the potential for future harm were his behaviour to be repeated. It is not for the IOPC to set the terms of the intervention, but I express my hope that among other things there may be reflection on the missed opportunity to offer an apology to Mr Taylor's family which you highlighted in your report.

Conclusion

I would like to myself express my sincere condolences to the family of Mr Taylor.

I am grateful to you for raising this issue with the IOPC and trust this response provides reassurance that I have considered the matter of concern raised in your report. Please do not hesitate to contact me if you have any queries arising from this letter.

¹ Paragraph 13.8, p154 Home Office Guidance Home_Office_Statutory_Guidance_0502.pdf (publishing.service.gov.uk)

Yours sincerely,



Regional Director

For the Director General