Racism Review Aggregate:
Recommendations Put Side By Side

This document is a verbatim list of all the recommendations made from the four parliamentary reviews mentioned by David Lammy. The reports from which all the recommendations have been taken are:

The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System by David Lammy MP

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

Report of the Independent Review of Deaths and Serious Incidents in Police Custody by Rt. Hon. Dame Elish Angiolini DBE QC

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf

Windrush Lessons Learned Review by Independent review by Wendy Williams

https://www.gov.uk/government/publications/windrush-lessons-learned-review

Race in the workplace; The McGregor-Smith Review by Baroness McGregor-Smith CBE

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/594336/race-in-workplace-mcgregor-smith-review.pdf

This document has been created to help people quickly see what issues have been flagged up and read the recommendations which have been made from previous parliamentary enquiries.

The Lammy Review

An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System

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Recommendation 1: A cross-CJS (criminal justice system) approach should be agreed to record data on ethnicity. This should enable more scrutiny in the future, whilst reducing ineffciencies that can come from collecting the same data twice. This more consistent approach should see the CPS and the courts collect data on religion so that the treatment and outcomes of different religious groups can be examined in more detail in the future.

Recommendation 2: The government should match the rigorous standards set in the US for the analysis of ethnicity and the CJS. Specifcally, the analysis commissioned for this review – learning from the US approach – must be repeated biennially, to understand more about the impact of decisions at each stage of the CJS.

Recommendation 3: The default should be for the Ministry of Justice (MoJ) and CJS agencies to publish all datasets held on ethnicity, while protecting the privacy of individuals. Each time the Race Disparity Audit exercise is repeated, the CJS should aim to improve the quality and quantity of datasets made available to the public.

Recommendation 4: If CJS agencies cannot provide an evidence-based explanation for apparent disparities between ethnic groups then reforms should be introduced to address those disparities. This principle of ‘explain or reform’ should apply to every CJS institution.

Recommendation 5: The review of the Trident Matrix by the Mayor of London should examine the way information is gathered, verifed, stored and shared, with specifc reference to BAME disproportionality. It should bring in outside perspectives, such as voluntary and community groups and expertise such as the Offce of the Information Commissioner.

Recommendation 6: The CPS should take the opportunity, while it reworks its guidance on Joint Enterprise, to consider its approach to gang prosecutions in general.

Recommendation 7: The CPS should examine how Modern Slavery legislation can be used to its fullest, to protect the public and prevent the exploitation of vulnerable young men and women.

Recommendation 8: Where practical all identifying information should be redacted from case information passed to them by the police, allowing the CPS to make race-blind decisions.

Recommendation 9: The Home Offce, the MoJ and the Legal Aid Agency should work with the Law Society and Bar Council to experiment with different approaches to explaining legal rights and options to defendants. These different approaches could include, for example, a role for community intermediaries when suspects are frst received in custody, giving people a choice between different duty solicitors, and earlier access to advice from barristers.
Recommendation 10: The ‘deferred prosecution’ model pioneered in Operation Turning Point should be rolled out for both adult and youth offenders across England and Wales. The key aspect of the model is that it provides interventions before pleas are entered rather than after.
Recommendation 11:The MoJ should take steps to address key data gaps in the magistrates’ court including pleas and remand decisions. This should be part of a more detailed examination of magistrates’ verdicts, with a particular focus on those affecting BAME women.

Recommendation 12: The Open Justice initiative should be extended and updated so that it is possible to view sentences for individual offences at individual courts, broken down by demographic characteristics, including gender and ethnicity.

Recommendation 13: As part of the court modernisation programme, all sentencing remarks in the Crown Court should be published in audio and/or written form. This would build trust by making justice more transparent and comprehensible for victims, witnesses and offenders.

Recommendation 14: The judiciary should work with Her Majesty's Courts and Tribunals Service (HMCTS) to establish a system of online feedback on how judges conduct cases. This information, gathered from different perspectives, including court staff, lawyers, jurors, victims and defendants, could be used by the judiciary to support the professional development of judges in the future, including in performance appraisals for those judges that have them.

Recommendation 15: An organisation such as Judicial Training College or the Judicial Appointments Commission should take on the role of a modern recruitment function for the judiciary – involving talent-spotting, pre-application support and coaching for 'near miss' candidates. The MoJ should also examine whether the same organisation could take on similar responsibilities for the magistracy. The organisation should be resourced appropriately to fulfll this broader remit.

Recommendation 16: The government should set a clear, national target to achieve a representative judiciary and magistracy by 2025. It should then report to Parliament with progress against this target biennially.

Recommendation 17: The MoJ and Department of Health (DH) should work together to develop a method to assess the maturity of offenders entering the justice system up to the age of 21. The results of this assessment should inform the interventions applied to any offender in this cohort, including extending the support structures of the youth justice system for offenders over the age of 18 who are judged to have low levels of maturity.

Recommendation 18: Youth offender panels should be renamed Local Justice Panels. They should take place in community settings, have a stronger emphasis on parenting, involve selected community members and have the power to hold other local services to account for their role in a child's rehabilitation.

Recommendation 19: Each year, magistrates should follow an agreed number of cases in the youth justice system from start to fnish, to deepen their understanding of how the rehabilitation process works. The MoJ should also evaluate whether their continued attachment to these cases has any observable effect on reoffending rates.

Recommendation 20: Leaders of institutions in the youth estate should review the data generated by the Comprehensive Health Assessment Tool (CHAT) and evaluate its effcacy in all areas and ensure that it generates equitable access to services across ethnic groups. Disparities in the data should be investigated thoroughly at the end of each year.

Recommendation 21: The prison system, working with the Department of Health (DH), should learn from the youth justice system and adopt a similar model to the CHAT for both men and women prisoners with built in evaluation.

Recommendation 22: The recent prisons white paper sets out a range of new data that will be collected and published in the future. The data should be collected and published with a full breakdown by ethnicity.

Recommendation 23:The MoJ and the Parole Board should report on the proportion of prisoners released by offence and ethnicity. This data should also cover the proportion of each ethnicity who also go on to reoffend.

Recommendation 24: To increase the fairness and effectiveness of the Incentives and Earned Privileges (IEP) system, each prison governor should ensure that there is forum in their institution for both offcers and prisoners to review the fairness and effectiveness of their regime. Both BAME and White prisoners should be represented in this forum. Governors should make the ultimate decisions in this area.

Recommendation 25: Prison governors should ensure Use of Force Committees are not ethnically homogeneous and involve at least one individual, such as a member of the prison's Independent Monitoring Board (IMB), with an explicit remit to consider the interests of prisoners. There should be escalating consequences for offcers found to be misusing force on more than one occasion. This approach should also apply in youth custodial settings.

Recommendation 26: Her Majesty's Prison and Probation Service (HMPPS) should clarify publicly that the proper standard of proof for assessing complaints is 'the balance of probabilities'. Prisons should take into account factors such as how offcers have dealt with similar incidents in the past.

Recommendation 27: Prisons should adopt a ‘problemsolving’ approach to dealing with complaints. As part of this, all complainants should state what they want to happen as a result of an investigation into their complaint.

Recommendation 28: The prison system should be expected to recruit in similar proportions to the country as a whole. Leaders of prisons with diverse prisoner populations should be held particularly responsible for achieving this when their performance is evaluated.

Recommendation 29: The prison service should set public targets for moving a cadre of BAME staff into leadership positions over the next fve years.

Recommendation 30: HMPPS should develop performance indicators for prisons that aim for equality of treatment and of outcomes for BAME and White prisoners.

Recommendation 31: The MoJ should bring together a working group to discuss the barriers to more effective sub-contracting by Community Rehabilitation Companies (CRCs). The working group should involve the CRCs themselves and a cross-section of smaller organisations, including some with a particular focus on BAME issues.

Recommendation 32: The Ministry of Justice should specify in detail the data CRCs should collect and publish covering protected characteristics. This should be written into contracts and enforced with penalties for noncompliance.

Recommendation 33: The Youth Justice Board (YJB) should commission and publish a full evaluation of what has been learned from the trial of its ‘disproportionality toolkit’, and identify potential actions or interventions to be taken.

Recommendation 34: Our CJS should learn from the system for sealing criminal records employed in many US states. Individuals should be able to have their case heard either by a judge or a body like the Parole Board, which would then decide whether to seal their record. There should be a presumption to look favourably on those who committed crimes either as children or young adults but can demonstrate that they have changed since their conviction.

Recommendation 35: To ensure that the public understands the case for reform of the criminal records regime, the MoJ, HMRC and DWP should commission and publish a study indicating the costs of unemployment among ex-offenders.

Report of the Independent Review of Deaths and Serious Incidents in Police Custody

Rt. Hon. Dame Elish Angiolini DBE QC

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Summary of Recommendations: Recommendations are grouped thematically. The corresponding Chapter numbers are in brackets at the end of each recommendation.

Restraint

1. Police practice must recognise that all restraint can cause death. Recognition must be given to the wider dangers posed by restraining someone in a heightened physical and mental state, where the system can become rapidly and fatally overloaded. Position is not always the determining feature. As great a danger can arise from the struggle against restraint as the restraint itself. (2)

2. There should be mandatory and accredited national training for police ofcers in restraint techniques, including de-escalation and supervision of vital signs during restraint, with appropriate refresher training for ofcers. There should be national consistency in approaches to the use of force. (2)

3. The grave dangers of prone and other forms of restraint in and of itself must be reiterated within forces in an effective manner and re-emphasised in training and retraining by all forces. (2)

4. ‘Excited Delirium’ should never be used as a term that, by itself, can be identifed as the cause of death. The use of Excited Delirium as a term in guidance to police ofcers should also be avoided. (2)

5. National policing policy, practice and training must reflect the now widely evident position that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life threatening risk. (2)

6. The restraint of anyone suffering a mental health crisis should be identifed in national policy and training as a high risk strategy giving rise to a medical emergency. Where all else has failed or life threatening circumstances demand, it should be used for the very shortest time possible and an ambulance should be called for immediate transportation to Accident and Emergency (2)

7. Restraint equipment should be strictly limited and subject to robust monitoring and review. Its use should form part of the mandatory training. (2)

Custody environment

8. A mandatory safety ofcer approach should be implemented by all police forces similar to that used in the prison setting. (2)

9. CCTV should be introduced in police vans nationally to allow monitoring of restrained detainees, in conjunction with vigilant supervision of welfare and safety during transport. Failure to maintain and ensure its proper functioning should be a disciplinary issue. Unforeseen CCTV failures should not result in a van being taken out of service if a detainee requires urgent transportation. (2)

10. HMIC should include a focus on inspection of observation regimes for intoxicated detainees within its Expectations of Police Custody (updated April 2016). HMIC should monitor police forces’ internal inspection procedures for observation regimes. (3)

11. Custody inspections should continue to focus on the use of liaison and diversion schemes, pre-release risk assessment, and actions taken on release, as part of the inspection regimes of police forces. (6)

12. Police forces should include medical input in the risk assessment process at the point of release, provided by the NHS (assuming medical services within police stations are brought within NHS commissioning). (6)
13. Local Authorities should ensure that they have reasonable systems in place to ensure that all police requests for accommodation, whether secure or non-secure, are accepted. Adequate funding must be made available for local authority overnight secure accommodation of children in police custody. (7)

14. Inspection fndings on the continuing use of overnight detention should feed directly into a national framework that links to departments for health and local government. (7)

15. The use of police custody for children detained under section 136 should be brought to an end with all NHS Trusts required to make sufcient provision of health-based places of safety to meet this requirement. (7)

16. Increased funding is required for appropriate adult schemes within a national framework for commissioning. This should include improved training and consistency of Appropriate Adult services. (7)

17. Custody procedures should be developed to lessen the impact of separation of mothers from young children. For example, supervised telephone contact around childcare issues should be prioritised and visits with children and their carers facilitated for longer detentions unless the nature of the alleged crime or the ongoing investigation prevents this. There should be monitoring of the extent to which police bail decisions take account of caring roles and the effects on the likelihood of absconding. (8)

18. The Government should consider whether Independent Custody Visitors schemes should have governance within HM Inspectorate. (12)

19. Privatisation of detention services should be avoided. Where private service providers are used the training of their staff should be to the same standards, preferably carried out jointly with police staff. They should be subject to the same processes of inspection and monitoring as police staff to ensure all-round compliance.

Protocols between private service staff and police staff should be fully embedded and employed in practice to avoid fragmentation of services. (12) Health and wellbeing

20. Healthcare professionals should take primary responsibility for the conduct and safe management of restraint of patients in any healthcare setting. This should be part of NHS and police policy. In the absence of support from other agencies the police may have to intervene with some form of restraint, but its use should be strictly limited and subject to robust monitoring and training. (2)

21. An NHS initiative at the national level should examine whether to prohibit the refusal of access to A&E or to health-based places of safety under section 136 Mental Health Act 1983 (section 136) on the basis of intoxication. It should also consider the redesign of A&E facilities to allow for safe areas, to protect the safety of other routine patients and staff from those suffering from severe intoxication. (3)

22. The Government should give consideration to the viability and cost-effectiveness of drying out centres, and consider piloting a centre or centres in large urban areas where it is most likely to be cost-effective, and linking such centres to existing A&E departments. An alternative would be the fundamental redesign of A&E departments to take into account this challenging situation. (3)

23. Joint local protocols should be established between police forces, ambulance services and hospitals to ensure appropriate medical care for intoxicated people in the appropriate environment. (3)

24. The use of police vehicles for transporting people detained under section 136 should be stopped in all but the most exceptional of situations. These are health emergencies (particularly where force has been used) and an ambulance should be summoned for all section 136 detainees. (4)

25. The use of police stations as section 136 ‘places of safety’ should be completely phased out. Guidance should not advocate the use of police custody on the grounds that a detainee’s behaviour would be ‘difcult to manage’ in a healthcare setting. (4)

26. Successful local mental health policing pilots and initiatives, particularly street triage and liaison and diversion schemes should be funded on a sustainable basis for national roll out so

that, as far as possible, those in mental health need are dealt with through medical and community based pathways not through police detention. Such schemes should be subject to regular review. (4)

27. There should be proper resourcing of national healthcare facilities to accommodate and respond to vulnerable people in urgent physical and/or mental health need coming into contact with the police. (4)

28. There should be clear procedures around the operation of section 136 from initial point of contact, including joint protocols between police, local health services and voluntary sector organisations. Health-based ‘places of safety’ should not be permitted to exclude those who are intoxicated or showing signs of agitated/aggressive/disturbed behaviour. (4)

29. An unambiguous and high threshold should be set for police involvement in any health care setting. Clear guidance should identify medical primacy of role in any health based setting involving the police. (4)

30. Independent investigations should always be held for all Article 2 related cases on NHS premises where there has been police involvement, or where someone died afer contact with the police. (11)

31. Forensic Medical Examiners and other medical services within police stations should be brought within NHS commissioning, in order to introduce minimum standards of medical care in police custody and so that medical records of the individual are quickly available to the doctor. (12)

32. Local joint protocols should be in place between all forces and their local ambulance service, mental health services and hospitals around ‘crisis planning’, particularly in respect of detainees suffering a mental health crisis and/or disturbed behaviour. Implementation of the protocols should be reviewed regularly and all staff must be familiar and confdent in the practices required by the protocols. (12) Funding for families and family support

33. In order to facilitate their effective participation in the whole process there should be access for the immediate family to free, non-means tested legal advice, assistance and representation from the earliest point following the death and throughout the preinquest hearings and Inquest hearing. (15)

34. Written information about sources of specialist support, including information about INQUEST, should be given to every family at the very frst contact with an IPCC representative, as well as alternative forms of information taking into account the needs of the individual next of kin. (9)

35. The Coroner and IPCC staff should tell families immediately following the death of their loved one of the right to independent free specialist legal advice, the beneft of securing advice from the earliest possible stage and the right to representation of a pathologist at the post mortem or to request a second post-mortem. (16)

36. This information should be regularly repeated during the progress of the investigation if the family have not sought legal advice at the earlier stage. The Coroner should provide information to families about the post-mortem examination before it takes place – including the time and location of the examination, and their right to have a representative present, and all other associated rights. (9)

37. Urgent consideration should be given to the mandatory video and audio recording of post-mortem examinations in contentious Article 2 deaths, with strict respect given to the control, storage and disclosure of recorded images. Wherever possible, such examinations should not take place until the family's chosen pathologist is in attendance. The video would serve as a record of the post-mortem but should not be used as a reason not to hold a second post-mortem examination if it is warranted. (16)

38. NHS Trusts should engage with families throughout their own investigations. There should be formal guidelines setting out the nature and expectations of family engagement. (11)

39. Where the NHS Trust is only one of a number of agencies investigating a death involving both police contact and NHS contact with the deceased there should be early, regular and formal communication and coordination with the IPCC and other agencies to minimise confusion, loss of evidence and delays. (11)

40. The Government should consider the feasibility of a scheme to pay reasonable travel and subsistence and compensation for loss of earnings for immediate family to attend the inquest in those inquests relating to deaths in police custody. Such a measure is necessary to ensure that access to the inquest hearing is a practical reality in every case. The Government should look at existing models, for example the support offered through Victim Support, when considering such a scheme. (15)

41. The Government should ensure that families have funded access to appropriate bereavement services offering specialist counselling to families of the deceased. Those providing the services should understand the impact of a traumatic bereavement involving a protracted, intrusive investigation. (15)

42. All state agencies who are engaged with the family, including police, IPCC, CPS and Coroners and their staff should provide both oral and written information about support services, including INQUEST, to families as early as possible when contact is established following the death. Agencies should not assume that this has already been done by others. (15)

43. Families should be provided with a private space for the duration of an inquest and treated with respect and dignity. There should also be designated family space within the courtroom itself. (16)

44. There should be a presumption that families should have access to the body of the deceased as soon as possible, even if this has to be through a screen or CCTV. Where this is not possible, the reasons must be explained clearly to the relatives with all necessary empathy, discretion and awareness of cultural and religious sensitivities. Steps should be taken to allow access as soon as possible once the forensic examination is complete and once it has been determined that a second post mortem is not to follow. (16)

45. Written information about sources of specialist support and legal advice should be passed to every family by the Coroner's Ofcer at the very frst contact. The Police and IPCC should also be subject to a legal obligation to advise the family of this right immediately on advising the family of the death. This may require translation services if English is not the frst language (16)

Communications

46. Following a death in police custody the police should immediately advise the Coroner as well as the IPCC of the fact and whereabouts of the death, and preserve the scene of the death from any potential interference. (16)

47. IPCC staff should to be vigilant about language and communication with families and of how their conduct and communication with police ofcers may be perceived by next of kin. Families should be invited to express concerns about anything said by IPCC staff which may give rise to doubts about independence. This should form part of the IPCC's learning and development around engagement with families. (9)

48. The roles of the Commissioner and the lead investigator need to be made clear to families in relation to all key aspects of the investigation from the earliest opportunity. (9) 49. In cases where the IPCC and HSE are actively involved, Coroners should hold prompt and regular pre-Inquest hearings requiring the agencies to liaise closely and account for the progress of their work and coordination. (14)

50. Before the IPCC has formerly taken over an investigation the police should make no public comment on the matter. Unless there are exceptional circumstances which require the urgent release of information the police should not issue any information to the media, but should leave this to the IPCC. (15)

51. Any information released to the media should be limited to very basic information about the deceased and the whereabouts of the death, and where possible, agreed in advance with the family, unless there are exceptional circumstances (for example a witness appeal) where time does not allow for this. (15)

52. Consideration should be given to the creation of statutory time limits for the investigation by the agencies unless there are to be criminal charges made and the Coroner suspends the Coroner's investigation. These time limits should be set by the Coroner following receipt of the report of the early meeting between the agencies. A pre-inquest hearing should be set before the expiry of that time limit or on cause shown in the event of a signifcant reason why the time limit cannot be met. (16)

53. Police and Crime Commissioners should report annually on deaths and serious incidents in police custody in their jurisdictions. (17)

54. The Home Secretary should provide an annual update to Parliament on the progress of implementation of the recommendations from this review. (17)

Investigations

55. Urgent consideration should be given to the development of an expert Deaths and Serious Injuries Unit of the IPCC for the investigation of all deaths in police custody in England and Wales. The Unit should be staffed by senior and expert officers from a non-police background. (9)

56. The IPCC should be resourced to provide a 24 hour national on call 'post incident' team with sufficient national coverage to ensure immediate response and attendance at a death or life threatening injury in custody within the shortest possible timeframe. Those attending should have experience of all steps necessary to protect a potential crime scene and secure evidence. The IPCC officer should be in constant contact with a senior member of the Deaths and Serious Injuries Unit for advice, guidance and further instruction until members of that Unit have arrived at the scene. (9)

57. IPCC investigators should consider if discriminatory attitudes have played a part in restraint-related deaths in all cases where restraint, ethnicity and mental health play a part (in line with the IPCC discrimination guidelines). A systematic approach should be adopted across the organisation. (5)

58. Ex-police officers should be phased out as lead investigators in the IPCC. To the extent that the IPCC still consider this expertise is required, ex-police staff should act as a consultancy and training source within and, more appropriately, outwith the organisation. The IPCC should also look beyond England and Wales for expert consultants and secondees from other investigative organisations who are also expert in the investigative, forensic skills required to investigate such serious cases, for example, from the Procurator Fiscal Service in Scotland and the Office of the Ombudsmen for Police in Northern Ireland. A wider pool of expert resources can also be considered by looking beyond the immediate jurisdiction of the IPCC. (9)

59. The IPCC should urgently consider whether to adopt a formal time limit for the completion of Article 2 investigations, with the lead investigator obliged to set out in writing why any extension to this limit was required. (9)

60. Police forces should be held accountable at the most senior level for protecting the scene when there is a death or serious incident in custody and preserving evidence until the arrival of the IPCC. Any failure to fulfl this role should be treated as a misconduct issue. Failure to maintain CCTV cameras and audio recording equipment in good working order should carry a disciplinary sanction. (9)

61. Investigations should maintain a strong focus on obtaining independent evidence, including prioritising CCTV coverage, mobile phone video recordings and the existence of independent witnesses during the immediate afermath of an incident as well as appropriate instruction of experts. (9)

62. Body worn cameras should be rolled-out nationally to all police ofcers working in the custody environment or in a public facing role. (10)

63. The IPCC draf guidance on post-incident procedures relating to separation of ofcers and non-conferral should be accepted by the Government. (10)

64. Other than for pressing operational reasons, police ofcers involved in a death in custody or serious incident, whether as principal ofcers or witnesses to the incident should not confer or speak to each other following that incident and prior to producing their initial accounts and statements on any matter concerning their individual recollections of the incident, even about seemingly minor details. As with civilian witnesses, all statements should be the honestly held recollection of the individual ofcer. (10)

65. There should be a duty for police ofcers to provide a full and candid statement at the earliest opportunity and within the specifed timeframe unless they are formal suspects. (13)

66. The IPCC should make clear in its guidance that minor discrepancies in statements given by police ofcers or any other witnesses to fact, are natural and are not presumed to be the outcome of dishonesty or incompetence. (10)

67. The Government should consider whether there is a need for a formal independent investigatory body for NHS Trusts in England and Wales. (11)

68. Where an individual dies during or following restraint involving both police and health personnel, a joint independent investigation by both the IPCC and the proposed independent investigatory body for the NHS should be closely aligned and coordinated in order to investigate the full circumstances of the death, including the conduct of the health personnel. (11)

69. Article 2 related cases should be dealt with in the same time scales as a civilian homicide case and the appropriate resources deployed by all agencies to achieve the completion of the investigation and decision making process within the robust timescale achieved in those cases. (13)

70. The CPS specialist unit handling prosecution decisions about deaths in police custody should be reviewed to ensure it is properly resourced with experienced prosecutors for consideration of such serious cases. (14)

71. There should be a formal meeting between the CPS, HSE, and IPCC within 14 days of a death or serious incident. This meeting should be chaired by the IPCC to discuss the emerging evidence, the probability and/or possibility of criminal charges and the nature of these charges, and be a precursor to regular cooperation and advice between these bodies for the duration of the investigation. The meeting should set a timetable to be submitted to the Coroner. The liaison should be formalised through a Memorandum of Understanding. (14)

Coroners and Inquests

72. A nationally funded National Coroner Service should be urgently considered as a means to address persistent inconsistencies of service and the inability of Coroners to pursue investigations without complete reliance on the IPCC and other agencies. (16)

73. A specialist cadre of ticketed and experienced Coroners should be created to preside over Article 2 inquests, under the auspices of a National Coroner Service. (16)

74. The 2013 Coroners (Investigations) Regulations should be amended to allow for a second post-mortem examination as of right, paid for by the state, in circumstances where no contact has been made with the family before the frst post-mortem occurred, except for exceptional circumstances where all reasonable efforts were made to contact the family in advance. (16)

75. The Chief Coroner should consider issuing guidance on what constitutes disclosure of relevant information and, subject to the superintendence of the High Court, how Coroners should approach the issue. (16)

76. The Chief Coroner should issue formal guidance to Coroners to prevent inappropriate or aggressive questioning of next of kin by counsel for interested persons at Inquest hearings. Coroners should be trained to be able to identify and prevent such styles of questioning where necessary. (16)

Accountability

77. Police must be held to account both at an individual and corporate level, where restraint has been found to have been used in an unnecessary, disproportionate or excessive way. (2)

78. The IPCC should address discrimination issues robustly within misconduct recommendations, including where discrimination is not overt but can be inferred from the evidence in that specifc case or similar cases involving the same ofcer. (5)

79. In Article 2 related deaths the IPCC should consider making a formal written request for the restriction of duties (in misconduct investigations) and the suspension of ofcers pending the outcome of gross misconduct and/or criminal investigations, although the fnal decision should remain with the Chief Constable. (13)

80. The IPCC should publish criteria for deciding on whether police action amounts to misconduct or gross misconduct. (13)

81. The IPCC should be responsible for informing all interested persons as soon as a misconduct hearing is arranged. There must be adequate notice for a family to attend, and their rights should be fully explained. (13)

82. The Government should consider whether there is a need for a family's role at a misconduct hearing to be clarifed, standardised and applied with more consistency, and advance disclosure of evidence to family members recognised as interested parties (subject to the harm test). (13)

83. Once clear criteria have been made open and transparent, dismissal should always follow fndings of gross misconduct unless there are wholly exceptional circumstances which justify a different sanction. Such exceptional circumstances must be fully explained to the family. (13)

Training

84. Comprehensive and standardised mandatory police training is required across forces for custody sergeants, ofcers and civilian detention staff on the dangers associated with intoxication. This should include medical input. (3)

85. Training for privatised detention and medical services must be to the same standard as for police staff and include joint training with custody sergeants and other ofcers working in the custody environment. Joint training is also required for Forensic Medical Examiners and custody sergeants. (3)

86. Police recruitment and training should incorporate the different personal skills and experiences needed to fulfl duties relating to the needs of highly vulnerable groups, including empathy, communication skills and the ability to employ de-escalation techniques. This should be embedded in the police appraisal process with assessment made on the correct use of force and, in particular, where ofcers have been able to avoid the use of force. (4)

87. National, comprehensive, quality assured mental health training consistent with the above is needed for all ofcers in front-line or custody roles. This should span all new recruits and regular refresher training. Training should be interactive and should involve mental health users to help break down fears and assumptions. (4)

88. National policing bodies and police forces should implement mandatory training and refresher training on the nature of discrimination, including on race issues, which aims to confront discriminatory assumptions and stereotypes. Policing bodies should consult with bereaved families on how such training can break down barriers and promote change. Training should take the form of a two-way dialogue allowing ofcers to hear the experiences of people from BAME backgrounds and include participation of bereaved families. Police training should include an understanding of institutional racism, the Macpherson report, the social context of Black deaths in custody and the impact they have had on public confdence. (5)

89. The College of Policing APP on detention and custody and force training should include guidelines for pre-release risk assessment setting out specifc practical steps that should be

taken to provide support and protection for those at risk of self-harm on release (for example contacting family/carers before release with the detainee's consent, or referrals to community support groups). (6)

90. Police training and inspection should focus on utilising non-secure accommodation for children other than in exceptional circumstances, where children pose a risk of harm to the public. (7)

91. Mandatory police training on vulnerability must include understanding of, and appropriate policing responses to those with learning disabilities and difculties, mental ill health, epilepsy or who are on the autistic spectrum as well as other conditions which may compromise the ability to communicate and understand police actions or processes. (8)

92. The use of support card schemes should be developed by all forces and included in police training. (8)

93. Police training should address the particular stressors that affect women detainees and young women in particular. Ofcers should understand the additional impact of these stressors upon women with mental health difculties and the importance of access to healthcare. (8)

94. Families should be involved on an ongoing basis with the provision of staff training in the IPCC including training on the impact of a traumatic bereavement (9)

95. Police forces, the IPCC, CPS, Coroners ofces and the College of Policing should give consideration to how family experiences can be brought into training and awareness packages. As a result of the tragic experience of the loss of a loved one in police custody many next of kin have become experts on a range of issues following a death in police custody and exposing ofcers to these families and listening to them is an invaluable training resource for all levels of command. (15)

Learning

96. Commitment and responsibility at leadership level is needed across police forces to ensure prioritisation of the issue of mental health and to bring about sustained cultural, organisational and practical changes. (4)

97. There should be consistent national police policy and guidance encompassing current learning and best operational practice, reflecting the need for a drastically improved policing approach to those in mental health need. (4)

98. The IPCC should ensure that race and discrimination issues are considered as an integral part of its work. This should be monitored and fed into internal learning and the IPCC's 'watchdog' role. (5)

99. The Ministerial Council on Deaths in Custody should conduct a review of its structures to consider whether those structures are suitable for purpose. (17)

100. The Government should consider whether there is a need for an independent Ofce for Article 2 Compliance, accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level. It should report publicly on the accumulated learning and compliance arising from Inquest outcomes and recommendations. It should provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work. (17)

101. An Ofce for Article 2 Compliance should oversee a coordinated, methodical and routine process around the dissemination of Coroners' PFD reports and jury fndings to all stakeholders, including (but not limited to) police forces, the College of Policing, the IPCC, and healthcare professionals. (17)

Statistics

102. The national 'use of force' data collection must be continually reviewed to ensure it provides the necessary transparency, auditing, active monitoring and opportunities for learning and training absent from the current system. Monitoring of ethnicity and mental health should be part of that system. More meaningful information should be requested from forms recording use of force. (2)

103. There should be robust data collection on near misses and non-fatal serious incidents by the police and IPCC. (2)

104. The IPCC should monitor the correlation between ethnicity and restraint-related deaths, including in healthcare settings where the police were involved. Statistics should be published breaking down restraint related deaths by ethnicity. (5)

105. The national programme for police data collection on the use of force must include ethnicity and mental health (as well as other factors relevant to discrimination) in all force data so as to provide a standardised national picture. (5)

106. National data collection on the use of force should be analysed by the Home Ofce to draw out patterns and devise national strategies to address discrimination issues. The outcome of data collection and analysis should be made public. (5)

107. The IPCC should monitor ethnicity and deaths in custody against ethnicity and arrests by reference to all arrests, including non-notifable offences. (5)

108. There should be mandatory ethnic monitoring of Gypsy Roma and Traveller communities in England and Wales by police forces in their ethnic monitoring systems. (5)

Research

109. Collaboration between pathologists, psychiatrists and emergency medicine practitioners is required to clarify and standardise the medical understanding around restraint-related deaths involving mental health crises. This should underpin future police training. An international conference and further urgent research is required to achieve consensus and better understanding. (2)

110. Independent international research should be carried out to look more closely at the safety of Conductive Energy Devices. (2)

Windrush Lessons Learned Review

Independent review by Wendy Williams

https://www.gov.uk/government/publications/windrush-lessons-learned-review

Go further to right the wrongs

Recommendation 1 – Ministers on behalf of the department should admit that serious harm was inficted on people who are British and provide an unqualifed apology to those affected and to the wider black African-Caribbean community as soon as possible. The sincerity of this apology will be determined by how far the Home Offce demonstrates a commitment to learn from its mistakes by making fundamental changes to its culture and way of working, that are both systemic and sustainable.

Recommendation 2 – The department should publish a comprehensive improvement plan within six months of this report, which takes account of all its recommendations, on the assumption that I will return to review the progress made in approximately 18 months' time.

Recommendation 3 – In consultation with those affected, and building on the engagement and outreach that has already taken place, the department should run a programme of reconciliation events with members of the Windrush generation. These would enable people who have been affected to articulate the impact of the scandal on their lives, in the presence of trained facilitators and/or specialist services and senior Home Offce staff and ministers so that they can listen and refect on their stories. Where necessary, the department would agree to work with other departments to identify follow-up support, in addition to fnancial compensation.

Recommendation 4 – The Home Secretary should continue the Windrush Scheme and not disband it without frst agreeing a set of clear criteria. It should carry on its outreach work, building on the consultation events and other efforts it has made to sustain the relationships it has developed with civil society and community representatives. This will encourage people to resolve their situation, while recognising that, for some, a great deal of effort will be required to build trust.

Look beyond the Caribbean

Recommendation 5 – The department should accept and implement the National Audit Offce's recommendation that,"The department should be more proactive in identifying people affected and put right any detriment detected. It should consider reviewing data on other Commonwealth cases as well as Caribbean nations", or such agreed variation to the recommendation as is acceptable to the National Audit Offce. In doing this work, the department should also reassure itself that no-one from the Windrush generation has been wrongly caught up in the enforcement of laws intended to apply to foreign offenders. The department should also take steps to publicly reassure the Windrush generation that this is the case.

Tell the stories of empire, Windrush and their legacy

Recommendation 6 – a) The Home Offce should devise, implement and review a comprehensive learning and development programme which makes sure all its existing and new staff learn about the history of the UK and its relationship with the rest of the world, including Britain's colonial history, the history of inward and outward migration and the history of black Britons. This programme should be developed in partnership with academic experts in historical migration and should include the fndings of this review, and its ethnographic research, to understand

the impact of the department's decisions; b) publish an annual return confrming how many staff, managers and senior civil servants have completed the programme.

Assess and limit the impact of the hostile environment on the Windrush generation

Recommendation 7 – The Home Secretary should commission offcials to undertake a full review and evaluation of the hostile/compliant environment policy and measures – individually and cumulatively. This should include assessing whether they are effective and proportionate in meeting their stated aim, given the risks inherent in the policy set out in this report, and its impact on British citizens and migrants with status, with reference to equality law and particularly the public sector equality duty. This review must be carried out scrupulously, designed in partnership with external experts and published in a timely way.

Engage meaningfully with stakeholders and communities

Recommendation 8 – The Home Offce should take steps to understand the groups and communities that its policies affect through improved engagement, social research, and by involving service users in designing its services. In doing this, ministers should make clear that they expect offcials to seek out a diverse range of voices and prioritise community-focused policy by engaging with communities, civil society and the public. The Windrush volunteer programme should provide a model to develop how the department engages with communities in future. The same applies to how it involves its staff in feeding back their information and knowledge from this engagement to improve policy and the service to the public.

Recommendation 9 – The Home Secretary should introduce a Migrants' Commissioner

responsible for speaking up for migrants and those affected by the system directly or indirectly. The commissioner would have a responsibility to engage with migrants and communities, and be an advocate for individuals as a means of identifying any systemic concerns and working with the government and the Independent Chief Inspector of Borders and Immigration (ICIBI) to address them.

Recommendation 10 – The government should review the remit and role of the ICIBI, to include consideration of giving the ICIBI more powers with regard to publishing reports. Ministers should have a duty to publish clearly articulated and justifed reasons when they do not agree to implement ICIBI recommendations. The ICIBI should work closely with the Migrants' Commissioner to make sure that systemic issues highlighted by the commissioner inform the inspectorate's programme of work.

Understand the public sector equality duty and immigration and nationality law

Recommendation 11 – The department should re-educate itself fully about the current reach and effect of immigration and nationality law, and take steps to maintain its institutional memory. It should do this by making sure its staff understand the history of immigration legislation and build expertise in the department, and by carrying out historical research when considering new legislation.

Recommendation 12 – The department should embark on a structured programme of training and development for all immigration and policy offcials and senior civil servants in relation to the Equality Act 2010 and the department's public sector equality duty (PSED) and obligations under the Human Rights Act 1998. Every year, the department should publish details of training courses attended, and how many people have completed them.

Recommendation 13 – Ministers should ensure that all policies and proposals for legislation on immigration and nationality are subjected to rigorous impact assessments in line with Treasury guidelines. Offcials should avoid putting forward options on the binary “do this or do nothing” basis, but instead should consider a range of options. The assessments must always consider whether there is a risk of an adverse impact on racial groups who are legitimately in the country. And consultation on these effects should be meaningful, offering informed proposals and openly seeking advice and challenge.

The department and its people

This group of recommendations aims to help the department clarify what it stands for and seeks to do. This will help it balance priorities, such as public protection and law enforcement, that can at times be in confict. These recommendations also aim to make the department’s culture less inward-looking, make its processes less complex for both its staff and the public, and to make it better at giving support to people who need it most. By following these recommendations, the department will:

• clarify the department’s purpose, mission and values
• develop a learning culture
• improve operational practice, decisionmaking and help for people at risk
• reduce the complexity of immigration and nationality law, immigration rules and guidance

Clarify the department’s purpose, mission and values

Recommendation 14 – The Home Secretary should a) set a clear purpose, mission and values statement which has at its heart fairness, humanity, openness, diversity and inclusion. The mission and values statement should be published and based on meaningful consultation with staff

and the public, and be accompanied by a plan for ensuring they underpin everyday practice in the department. The department should set its mission and values statement in consultation with its staff, networks and other representative bodies, the public, communities and civil society, and publish it online; b) translate its purpose, mission and values into clear expectations for leadership behaviours at all levels, from senior offcials to junior staff. It should make sure they emphasise the importance of open engagement and collaboration, as well as valuing diversity and inclusion, both externally and internally. The performance objectives of leaders at all levels should refect these behaviours, so that they are accountable for demonstrating them every day.

Develop a learning culture

Recommendation 15 – a) The Home Offce should devise a programme of major cultural change for the whole department and all staff, aimed at encouraging the workforce and networks to contribute to the values and purpose of the organisation and how it will turn them into reality. It should also assure itself as to the effcacy of its organisational design. Outputs could include independently chaired focus groups to let staff of all grades and areas of work (particularly under-represented groups) describe their lived experience, including working within the department and suggest what needs to change in terms of the department's mission, values and culture; b) The Permanent Secretary and Second Permanent Secretary should lead the process, with the support of the senior leadership, who should commit to agreeing a programme with senior-level accountability, including clear actions, objectives and timescales; c) The workforce and staff networks should help devise the success criteria for the programme and a senior member of the leadership team should be the sponsor for the programme; d) The department should invest in, develop and roll out a leadership development programme for all senior, middle and frontline managers where leadership behaviours and values will be made clear.

Recommendation 16 – The Home Offce should establish a central repository for collating, sharing and overseeing responses and activity resulting from external and internal reports and recommendations, and adverse case decisions. This will make sure lessons and improvements are disseminated across the organisation and inform policy-making and operational practice. Improve operational practice, decision-making and help for people at risk

Recommendation 17 – The Home Offce should develop a set of ethical standards and an ethical decision-making model, built on the Civil Service Code and principles of fairness, rigour and humanity, that BICS staff at all levels understand, and are accountable for upholding. The focus should be on getting the decision right frst time. The ethical framework should be a public document and available on the department's website. A system for monitoring compliance with the ethical standard should be built into the Performance Development Review process.
Recommendation 18 – The Home Offce should establish more and clearer guidance on the burden and standard of proof particularly for the information of applicants, indicating more clearly than previously how it operates and what the practical requirements are upon them for different application routes. The decision-making framework should include at least guidelines on when the burden of proof lies on the applicant, what standard of proof applies, the parameters for using discretion and when to provide supervision or ask for a second opinion. This should produce more transparent and more consistent decision-making.

Recommendation 19 – a) UK Visas and Immigration should ensure that where appropriate it builds in criteria for increasing direct contact with applicants, including frequency of contact, performance standards and monitoring arrangements; revises the criteria and process for assessing cases involving vulnerable applicants; and reviews its service standards and where

appropriate provides new standards based on qualitative as well as quantitative measures; UKVI should ensure it revises its assurance strategy; disseminates the learning from recent Operational Assurance Security Unit (OASU) or internal audit reviews; identifes criteria and a commissioning model for OASU or internal audit reviews; contains clear mechanisms for reporting back casework issues to frontline staff, and criteria for supervision, including recording outcomes and learning for the wider organisation; b) the department should review the UK Visas and Immigration assurance strategy periodically to make sure it is operating effectively, and the reviews should consult practitioners as well as specialist staff to make sure the strategy changes if it needs to.

Recommendation 20 – The Home Secretary should commission an urgent review of the BICS complaints procedure. Options could include establishing an Independent Case Examiner as a mechanism for immigration and nationality applicants to have their complaints reviewed independently of the department.
Reduce the complexity of immigration and nationality law, immigration rules and guidance

Recommendation 21 – Building on the Law Commission's review of the Immigration Rules the Home Secretary should request that the Law Commission extend the remit of its simplifcation programme to include work to consolidate statute law. This will make sure the law is much more accessible for the public, enforcement offcers, caseworkers, advisers, judges and Home Offce policy makers.

The department's role in wider government

My third set of recommendations focuses on the internal systems that prevented the Home Offce anticipating the scandal sooner, and stopped it anticipating the risks. The operational risks the department monitors need to include service delivery and

protecting the public, as well as reputational damage to the department. And better quality data, management information and performance measurement would have reduced these risks.

This group of recommendations also underlines the curiosity and constructive challenge that should characterise the relationship between ministers and offcials.

Look for risks and listen to early warning signs

Recommendation 22 – The Home Offce should invest in improving data quality, management information and performance measures which focus on results as well as throughput. Leaders in the department should promote the best use of this data and improve the capability to anticipate, monitor and identify trends, as well as collate casework data which links performance data to Parliamentary questions, complaints and other information, including feedback from external agencies, departments and the public (with the facility to escalate local issues). The Home Offce should also invest in improving its knowledge management and record keeping.

Recommendation 23 – The department should revise and clarify its risk management framework, where offcials and ministers consider potential risks to the public, as well as reputational and delivery risks.

Emphasise the role of ministers and senior offcials

Recommendation 24 – The department should invest in training for the Senior Civil Service to ensure appropriate emphasis on the roles and responsibilities of offcials to provide candid, comprehensive and timely advice to ministers.

Recommendation 25 – All policy submissions and advice to ministers should have mandatory

sections on: a) risks to vulnerable individuals and groups and b) equalities, requiring offcials to consider the effect of their proposals in these terms. The department should review the effectiveness of its current processes and criteria for escalating signifcant policy submissions for approval by the Permanent Secretary or Second Permanent Secretary. Where necessary new processes and criteria should be established.

Recommendation 26 – The department should put in place processes to support the use of the electronic archive to record all departmental submissions, minutes, and decisions centrally so there is a clear audit trail of policy deliberations and decisions. The department should ensure staff are provided with guidance on the knowledge and information management principles in respect of their work with/support for ministers. This archive should enable users to search for key terms, dates and collections on particular policy risks or issues.

Race

Recommendation 27 – The department should establish an overarching strategic race advisory board, chaired by the Permanent Secretary, with external experts including in relation to immigration and representation from The Network6 to inform policy-making and improve organisational practice.

Recommendation 28 – Subject to relevant statutory provisions, such as s10 Constitutional Reform and Governance Act 2010, the department should revise its Inclusive by Instinct diversity and inclusion strategy to include its aspirations for senior-level BAME representation and a detailed plan for achieving them. Action should form part of a coherent package with ambitious success measures and senior-level ownership and accountability. The department should publish comprehensive annual workforce data, so it can monitor progress.

Recommendation 29 – The department should:

a) review its diversity and inclusion and unconscious bias awareness training (over and above the mandatory civil service online courses) to make sure it is consistent with achieving the objectives of the Inclusive by Instinct strategy and that it is designed to develop a full understanding of diversity and inclusion principles, and the principles of good community relations and public service

b) produce a training needs analysis and comprehensive diversity and inclusion training plan for all staff

c) provide refresher training to keep all current and new staff up to date

d) involve other organisations, or experts in the feld of diversity and inclusion in its design and delivery

e) set and then publish standards in terms of its diversity and inclusion training aims and objectives

f) monitor learning and development regularly to test implementation and whether it is achieving its strategic objectives

g) carry out regular “pulse” surveys to test the effectiveness of the implementation of these measures

Recommendation 30 – the Home Offce should regularly review all successful employment tribunal claims that relate to race discrimination, harassment or victimisation, and in particular a summary of every employment tribunal judgment fnding against the Home Offce of race discrimination should be emailed to all SCS within 42 days of the decision being sent by the tribunal together with a note stating whether an appeal has been instituted. The same arrangements

should be made for Employment Appeal Tribunal, High Court, Court of Appeal or Supreme Court judgments within 28 days. It should use any learning to improve staff and leadership training, and to feed back to the senior civil service.

Race in the workplace The McGregor-Smith Review

by Baroness McGregor-Smith CBE

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/594336/race-in-workplace-mcgregor-smith-review.pdf

List of recommendations

1. Published, aspirational targets: Listed companies and all businesses and public bodies with more than 50 employees should publish fve-year aspirational targets and report against these annually.

2. Publicly available data: Listed companies and all businesses and public bodies with more than 50 employees should publish a breakdown of employees by race and pay band.

3. Encourage employees to disclose: All employers should take positive action to improve reporting rates amongst their workforce, explaining why supplying data will improve diversity and the business as a whole.

4. Government legislation: Government should legislate to ensure that all listed companies and businesses employing more than 50 people publish workforce data broken down by race and pay band.

5. Free unconscious bias resource online: The Government should create a free, online unconscious bias training resource available to everyone in the UK.

6. Mandatory unconscious bias training: All organisations should ensure that all employees undertake unconscious bias training.

7. Unconscious bias workshops for executives: Senior management teams, executive boards and those with a role in the recruitment process should go further and undertake more comprehensive workshops that tackle bias.

8. Executive sponsorship: All businesses that employ more than 50 people should identify a board-level sponsor for all diversity issues, including race. This individual should be held to account for the overall delivery of aspirational targets. In order to ensure this happens, Chairs, CEOs and CFOs should reference what steps they are taking to improve diversity in their statements in the annual report.

9. Diversity as a Key Performance Indicator: Employers should include a clear diversity objective in all leaders' annual appraisals to ensure that they take positive action seriously.

10. Reverse mentoring: Senior leaders and executive board members should undertake reverse mentoring with individuals from different backgrounds, to better understand their unique challenges as well as the positive impacts from diversity.

11. Reject non-diverse lists: All employers should ensure proportional representation on long and short lists, and reject lists that do not reflect the local working age population.

12. Challenge school and university selection bias: All employers should critically examine entry requirements into their business, focusing on potential achievement and not simply which university or school the individual went to.

13. Use relevant and appropriate language in job specifcations: Job specifcations should be drafted in plain English and provide an accurate reflection of essential and desirable skills to ensure applications from a wider set of individuals.

14. Diverse interview panels: Larger employers should ensure that the selection and interview process is undertaken by more than one person, and should ideally include individuals from different backgrounds to help eliminate bias.

15. Transparent and fair reward and recognition: Employers should ensure that all elements of reward and recognition, from appraisals to bonuses, reflect the racial diversity of the organisation.

16. Diversity in supply chains: All organisations (public and private) should use contracts and supply chains to promote diversity, ensuring that contracts are awarded to bidders who show a real commitment to diversity and inclusion.

17. Diversity from work experience level: Employers should seek out opportunities to provide work experience to a more diverse group of individuals, looking beyond their standard social demographic (this includes stopping the practice of unpaid or unadvertised internships).

18. Transparency on career pathways: New entrants to the organisation should receive a proper induction, including basic and clear information on how the career ladder works, pay and reward guidelines and how promotions are awarded.

19. Explain how success has been achieved: Senior managers should publish their job history internally (in a brief, LinkedIn style profle) so that junior members of the workforce can see what a successful career path looks like.

20. Establish inclusive networks: Employers should establish formal networks and encourage individuals to participate, incorporating the networks' objectives into the mission of the company.

21. Provide mentoring and sponsorship: Mentoring and sponsorship schemes should be made available to anyone who wants them.

22. A guide to talking about race: Government should work with employer representatives and third sector organisations to develop a simple guide on how to discuss race in the workplace.

23. An online portal of best practice: Government should work with Business in the Community to establish an online portal for employers to source the information and resources they need to take effective positive action.

24. A list of the top 100 BME employers in the UK: Business in the Community should establish a list of the top 100 BME employers, to identify the best employers in terms of diversity.

25. Request for diversity policies: Government to write to all institutional funds who have holdings in FTSE companies and ask them for their policies on diversity and inclusion and how they ensure as owners of companies that the representation of BME individuals is considered across the employee base of the companies where they hold investments

26. One year on review: Government should assess the extent to which the recommendations in this review have been implemented, and take necessary action where required.