Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies

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Introduction

1. Every death in police custody is a tragedy; one death is one too many. Such deaths are largely preventable. Police leadership is key to keeping people safe and honouring the duty to take active steps to protect lives.

2. This report by the Independent Advisory Panel on Deaths in Custody (IAPDC) draws together examples of active steps to protect lives submitted by 28 forces and three police representative bodies across England and Wales. It outlines ways, identified as effective by forces, to prevent deaths at the point of arrest, during police custody, and after release. It shows how learning can be derived and embedded from such deaths to prevent future deaths.

3. The report needs to be considered in the context of a renewed emphasis on getting the basics of policing right.[1] The evidence suggests that the majority of police time is spent on incidents unrelated to criminality, with data from HM Inspectorate of Constabulary & Fire Rescue Services (HMICFRS) suggesting that in 2016/17 only 24% of the incidents to which forces responded related to crime.[2] Reducing crime and building public confidence are at the top of the police agenda. Keeping people safe garners public trust. Many forces have forged partnerships with allied health and justice services to play to professional strengths. Partnership working can reduce inappropriate use of police time and serve to prevent deaths in custody.

4. The number of deaths during and following police custody has remained at similar levels for the last decade, while deaths within custody itself have fallen. There were 11 deaths in or following police custody in 2021/22, a decrease of 8 from the previous year, as well as 56 apparent suicides following release from police custody, one more than the previous year.[3] In 2021/22, three people died in a police cell, a continuation of a long-term reduction since the 1990s from earlier years.[4]

5. The findings from inquests into the deaths of Kevin Clarke and Kelly Hartigan Burns, amongst others, have provided a stark reminder of matters of concern which have yet to be rectified.[5] Many of the deaths have generated concern about the use of force by police officers and the care of people with mental health conditions, and resulted in

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[1] See, for reference, Home Secretary the Rt Hon Suella Braverman KC MP, 'Open letter to leaders of the police for England and Wales', 23 September 2023, available at: https://www.gov.uk/government/publications/home-secretary-letter-to-police-leaders/open-letter-to-leaders-of-the-police-for-england-and-wales-accessible; Home Affairs Select Committee, 'Call for evidence: policing priorities', available at: https://committees.parliament.uk/call-for-evidence/2704/; Martin Hewitt, Chairman of the National Police Chiefs' Council, 'We want to give people peace of mind that if you experience a burglary, officers will come... It's a key step in building trust in the police, writes National Police Chiefs' Council chairman MARTIN HEWITT', in *Daily Mail*, 4 October 2022, available at: https://www.dailymail.co.uk/news/article-11281043/Police-attend-domestic-burglary-scenes-claim-chief-constables.html.

[2] See Comptroller and Auditor General, *Financial Sustainability of Police Forces in England and Wales 2018*, Session 2017–2019, HC 1501, National Audit Office, 2018, p. 27, available at: https://www.nao.org.uk/wp-content/uploads/2018/09/Financial-sustainability-of-police-forces-in-England-and-Wales-2018.pdf; see also Institute for Government, *Performance Tracker 2019: Police*, available at: https://www.instituteforgovernment.org.uk/publication/performance-tracker-2019/police.

[3] Independent Office for Police Conduct, 'IOPC publishes figures on death during or following police contact for 2021/22', 28 September 2022. Available at: https://policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-202122.

[4] In 2020/21, three people died in a police cell, in 2019/20 one person died in a police cell, in 2018/19 there were no such deaths, and in 2017/18 there were three such deaths.

[5] Andrew Harris, *Regulation 28 Report to Prevent Future Deaths: Kevin Clarke 2021-0046,* 18 February 2021. Available at: Kevin-Clarke-2021-0046-Redacted.pdf (judiciary.uk); Emma Whitting, *Regulation 28 Report to Prevent Future Deaths: Leon Briggs, 12 October 2021*. Available at: https://www.judiciary.uk/wp-content/uploads/2021/10/Leon-Briggs-Prevention-of-future-deaths-report-2021-0330_Published.pdf; INQUEST, Kelly Hartigan-Burns: Inquest finds litany of failures in Lancashire police custody death, 7 April 2022, https://www.inquest.org.uk/kelly-hartigan-burns-inquest-concludes.

Prevention of Future Death reports from coroners. In 2022 the deaths of people in mental health crisis and black men following the use of force by police officers have generated significant community concern.[6] The focus now must be on preventing all deaths at point of arrest, in police custody and following contact.

6. A high proportion of deaths that occur in police custody, during or following police contact, involve people who are experiencing mental health and and/or substance misuse issues. In 2021/22, 6 of the 11 people who died were identified as having mental health conditions and 9 people were known to have links to alcohol and/or drugs.[7] Both factors are also prevalent among the 109 people who died in 2021/22 after some form of contact with the police. It is important to note that the category of 'other deaths following police contact' includes concerning examples of police contact deaths but whose classification remain opaque, as do what themes and learning are drawn from it.[8]

7. Following discussion at the Ministerial Board on Deaths in Custody, in 2021 the IAPDC embarked on an information gathering exercise (outlined in Annex A) to determine how best individual forces worked to prevent, respond to and learn from deaths at the point of arrest, during police custody and after release. This exercise was spearheaded by then-Policing Minister Rt Hon Kit Malthouse MP who affirmed his and his Government's zero-tolerance approach to deaths in police custody. He said: "The Government is committed to delivering meaningful and lasting change to prevent deaths in police custody."

8. Recommendations and considerations for forces, departments and partners focus on three key areas: mental health and risk, reducing apparent post-custody suicides and embedding learning.

    a. **Mental health and risk.** While schemes such as street triage, custody liaison and diversion, and emergency places of safety ensure those in crisis can receive appropriate treatment, there is variance in the way these schemes operate and their availability.

    b. **Apparent post-custody suicides**. Robust pre-release assessments are needed to identify early warning signs of behaviour linked to a risk of suicide and steps taken with partner agencies to mitigate this risk.

    c. **Embedding learning.** Ensuring forces implement changes after a death in custody is vital, especially for bereaved families who repeatedly make clear their wish that no other family should go through the same experience as they have.

9. The exercise also invited views on leadership, gaps in provision, disproportionality, and how the Ministerial Board on Deaths in Custody and the IAPDC can assist Police and Crime Commissioners (PCCs) and police forces to make progress in these areas.

10. **The purpose of this report is to highlight the range of steps taken by forces to protect lives, which were submitted as examples of good local practice, for the benefit of all PCCs, forces and other policing organisations.** Given accounts of successful partnership working as well as reference to barriers still to overcome, the IAPDC trusts that it will also be of value to the NHS, the ambulance service and other health and justice organisations. The publication of the Government's progress report

[6] For example, the Guardian, *Chelsea Bridge death: family say Met police wrong to Taser man*, 22 August 2022. Available at: Chelsea Bridge death: family say Met police wrong to Taser man | Metropolitan police | The Guardian; the Guardian, *Inquiry after 93-year-old man with one leg dies after being Tasered by police*, 4 August 2022. Available at: Inquiry after 93-year-old man with one leg dies after being Tasered by police | Police | The Guardian.
[7] Independent Office for Police Conduct, *Deaths during or following police contact: Statistics for England and Wales 2020/21,* July 2020. Available at: deaths_during_following_police_contact_202021.pdf (policeconduct.gov.uk)
[8] Independent Office for Police Conduct, *Deaths during or following police contact: Statistics for England and Wales 2020/21.*

against the recommendations made in the Angiolini Review adds impetus to this report's findings and recommendations.[9]

11. The IAPDC recognises the range of existing expert reports and resources which set out recommendations and good practice to prevent deaths. We reiterate their importance and the ongoing need to review and enact their recommendations. These include *Six Missed Chances*[10], which followed the death during restraint of James Herbert, a man in mental health crisis restrained by Avon and Somerset Police; the *Adebowale Commission*, which followed the death of Sean Rigg[11]; the police training video '60 seconds to save a life';[12] and the landmark *Report of the independent review of deaths and serious incidents in police custody* (the Angiolini Review), prompted by the restraint deaths of two black men Sean Rigg and Olaseni Lewis. The intention of this report and its recommendations is not to 'reinvent the wheel' but to amplify examples of police practice and draw conclusions from the evidence presented through the information-gathering exercise.

12. **While reference was made in the information gathering exercise to the use of force and disproportionality in regard to race, input on these points was minimal. This omission is a matter of concern**. The panel will continue to request examples and encourage reflection on these issues as the initiative moves forward.

13. There has been positive progress at the national level to address some of the key issues. The Government has taken steps to ensure the full removal of police stations as designated 'places of safety' for people experiencing a mental health crisis, including through a proposed ban via the Draft Mental Health Bill, and the Department of Health and Social Care has rolled out NHS England and NHS Improvement-commissioned liaison and diversion services to ensure when vulnerable people are in custody that their needs are identified. The College of Policing is currently revising and implementing the curriculum for Personal Safety Training. This training is outcomes based on real life like scenarios and focuses on conflict management and de-escalation.

14. Police and Crime Commissioners (PCCs) have an important leadership role to play in the prevention of deaths in custody. This is especially true in light of the announcement that the Government intends to grant PCCs wider functional powers of competence to promote innovation, ambition and creativity in tackling crime and public safety issues and facilitate PCCs playing a greater role in the criminal justice system "particularly in the respect of offender management by providing them with the tools and levers to enhance wider public service delivery through forming effective partnerships with housing, education, health partners", potentially giving them "the ability to tackle issues outside of policing, such as community safety, or enable them to have more influence over criminal justice agencies where there are evident shared priorities and outcomes locally."[13]

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[9] Home Office, *Deaths in police custody: progress update 2021*, July 2021. Available at: Deaths in police custody: progress update 2021 (accessible) - GOV.UK (www.gov.uk).
[10] Independent Police Complaints Commission, *Six Missed Chances: How a different approach to policing people with mental health problems could have prevented James Herbert's death in custody*, September 2017. Available at: https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/James_Herbert_Six_missed_chances.pdf.
[11] Lord Adebowale, *Independent Commission on Mental Health and Policing*, May 2013. Available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiW24bv9NL3AhXloFwKHUxHCeYQFnoECAIQAQ&url=https%3A%2F%2Fwww.london.gov.uk%2Fabout-us%2Flondonassembly%2Fmeetings%2Fdocuments%2Fs30427%2FMental%2520Health%2520and%2520Policing%2520Report.doc%3FCT%3D2&usg=AOvVaw32cqR-x7BqAM76-PZWKNvx
[12] Available at: https://news.npcc.police.uk/releases/police-launch-new-video-about-responding-to-medical-situations-in-custody.
[13] Home Office, *Giving Police and Crime Commissioners (PCCS) greater powers of competence: government response,* 8 March 2022. Available at: Giving Police and Crime Commissioners (PCCs) greater powers of competence: government response - GOV.UK (www.gov.uk).

Summary of key themes

The following section outlines some of this report's key findings.

Leadership and prioritisation

15. A number of submissions emphasised the importance of good leadership and clear accountability. Some gave examples of how these were underpinned by new structures, performance management and training.

Mental health and risk

16. PCCs and Chief Constables frequently highlighted concerns about responding to individuals in mental health crisis.[14] The responses we received were consistent in affirming that positive relationships with mental health professionals – such as custody-based Liaison and Diversion (L&D) teams or practitioners who support first responders – are of paramount importance. Forces are clearly aware of the need for further work, including in collaboration across agencies with the NHS and others, to support the mental health of detainees. Northumbria, for example, has made mental health a priority for its 2021-2025 Police and Crime Plan, and will undertake a survey of mental health needs to inform this.

17. Different cross-agency schemes, such as street triage and L&D support, exist to support those with mental health and substance misuse problems. However, such initiatives can vary between forces in terms of operating hours, practice and coverage. Of further concern is the lack of availability in some forces of mental health support during the night hours. This means that potentially vulnerable people are sometimes left waiting until the morning to be seen. This can often mean prolonged periods in an unsuitable environment or overreliance on staff not trained in assessment of mental health risk to make a judgement.

18. Many PCCs emphasised the limited availability of mental health support at the point of contact for vulnerable people in the community and, at times, a lack of appropriately trained staff in police custody. These concerns also extend to finding appropriate alternative places of safety to take care of detainees. Further, some forces commented on the need to take individuals outside of their area should they require a hospital bed under the Mental Health Act. PCCs outlined ongoing work within custody, including mandatory training on mental health for all custody staff, but many of the challenges forces face in this area relate to availability of wider mental healthcare provision. This is reflected in His Majesty's Inspectorate of Constabulary and Fire Rescue Services (HMICFRS) 2022 *State of Policing* report which highlights inadequacies and delays in accessing good-quality mental health service provision, which have only worsened during the pandemic.[15]

Apparent post-custody suicides

19. PCCs are aware of the concerning number of apparent suicides following release, which is consistently greater than the number of deaths occurring within custody. All but two of the respondents highlighted assessments which are carried out pre-release to screen for risk of future self-harm. This can include multi-agency approaches to mental health and general wellbeing, and efforts to signpost individuals to support, for example, through leaflets and posters in custody suites. Some responses pointed out the dual nature of the police role here both as enforcer and supporter and the inherent tension in this role.

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[14] Association of Police and Crime Commissioners, *APCC Briefing: Mental Health & Covid19: Phase One Summary,* January 2021. Available at: https://www.apccs.police.uk/media/5930/apcc-briefing-phase-1-mh-c19-final.pdf ; Association of Police and Crime Commissioners, *APCC Briefing: Mental Health & Covid19: Phase Two Report,* July 2021. Available at: https://www.apccs.police.uk/media/6493/apcc-mh-inquiry-phase-two-report-final.pdf.

[15] HMICFRS, *State of Policing – the Annual Assessment of Policing in England and Wales 2021,* 2022. Available at: State of Policing 2021 (justiceinspectorates.gov.uk).

20. Despite recognition of the need to assess individuals prior to release, there does not appear to be a great deal of evidence as to police practice concerning follow-up or after-care. Most of the support seems to be reliant on self-help, proactive take-up of advertised services or the good-will of family members and friends. In a few areas, follow-up support by L&D services is available for up to 12 weeks after release. However, most forces do not have such a care pathway in place in their area, and focus could be given to building more proactive links with community and third-sector mental health services.

Embedding learning

21. Internally some forces appear to have positive structures to learn lessons and retain the prevention of deaths in custody at the forefront of the minds of staff. Positive work includes regular structured meetings chaired at a senior level between police and health staff; the dissemination of bulletins, including the Independent Office for Police Complaints (IOPC) 'Learning the Lessons', which act as reference sources for good practice information; the implementation and monitoring of recommendations made by coroners in prevention of future death reports; and bespoke training on aspects including handover processes, understanding neurodiversity and reflective practice. Very few responses referred to how learning was shared between forces or described the liaison with, learning from, or the respectful provision of feedback to bereaved families.

22. After outlining recommendations for police and partners, the remainder of this report summarises the range of active steps to protect lives, identified as examples of good practice in PCC responses, grouped by the three priority areas, and considers next steps.

Recommendations and considerations for forces, departments, the NHS and health and justice partners

The IAPDC recognises the range of partners in this area – including police forces, healthcare, ambulance associations, local authorities and voluntary organisations – have varying delivery models, and that good practice examples will often need to be adapted to fit local context, pressures, and structures. There are, however, improvements which can and should be made, as well as overarching principles which must be adhered to, in order to prevent deaths at point of arrest, during and after police custody.

Mental health and risk

1. **Individual forces and healthcare partners should develop and implement an agreement about mental health response in their area.** Building on progress made by the cross-agency Mental Health Crisis Care Concordat, understanding must be developed and shared of what support is needed when the police are called to incidents involving individuals who are in significant distress and/or may have mental health or neuro-divergent conditions, and where disability or distress is the primary reason for the police being called. Incidents of acute behavioural disturbance (ABD) should be treated as medical emergencies.[16] Whilst recognising the independence of forces, the National Police Chiefs Council together with NHS England and the Ambulance Service, as well as local authorities, the Association of Directors of Adult Social Services, and other partners, should review and consider agreed ways of working, including priority response, handovers and referrals for mental health provision and social care. These models should be monitored by relevant inspectorates whose subsequent recommendations could be followed-up, with co-ordinated progress responses made by Police and Crime Commissioners.

2. **Steps should be taken to ensure a greater scale and coverage of mental health support**. Although general healthcare, including within police custody, is usually provided on a 24-hour basis, mental health support through liaison and diversion services is patchier during the out-of-hours period. The Home Office, Department of Health and Social Care (DSHC), NHS England, Welsh Government Department of Health and Social Services, NHS Wales, Police and Crime Commissioners, and individual forces should continue to support the rollout of comprehensive street triage and liaison and diversion schemes, or their equivalent, in line with findings from recent evaluations (cited below).

3. **Police and Crime Commissioners should scrutinise the use of adequate risk assessment procedures and protocols on safeguarding for suicide prevention, drug and alcohol misuse.** This includes markers on the Police National Computer, medication checks, and monitoring of protection of vulnerable people reports.

4. **While we recognise the range of existing training available for forces, individual forces and liaison and diversion staff, supported by the College of Policing, NHS England, Royal College of Nursing, and the National Police Chiefs Council mental health and neurodiversity leads should be consulted to assist in the production of mental health and neurodivergent awareness**

[16] Royal College of Psychiatrists, '*Acute behavioural disturbance' and 'excited delirium'*, September 2022. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_22.pdf.

training. Commissioners of liaison and diversion services should include the provision of mental health and neurodivergent awareness training for police officers, involving those with lived experience and bereaved families in training where appropriate.

5. **The Department of Health and Social Care and the Home Office must end the use of police custody as a place of safety**, as recommended by Sir Simon Wessely in his review and the intent set out in the *Reforming the Mental Health Act* White Paper, now the Draft Mental Health Bill. This will require funding for a range of mental health services, including ambulance/mental health conveyance vehicles, well-staffed places of safety, mental health beds, and investment in staff and initial training. The Department of Health and Social Care and the Home Office should set, and adhere to, ambitious target deadlines for meeting this objective.

6. **NHS Integrated Care Boards and Foundation Trusts must take steps to ensure adequate inpatient facilities are available for urgent admission under the Mental Health Act.** The onus for this should not be placed on frontline police officers.

Reducing apparent post-custody suicides

7. **Individual forces should liaise with liaison and diversion services, local health providers and community and voluntary sector organisations to explore options for support available on release for any person identified as at risk of self-inflicted death.** This could be strengthened by a greater collation of information relating to the type of services offered to those bailed from custody. The onus on effective 'aftercare' must not fall solely on the police. At the same time, forces will often be best placed to understand the situation a person may be in after being held in police custody, and therefore should signpost or refer individuals to support. Current post-release arrangements facilitated by liaison and diversion services in Northumbria and Nottinghamshire should be considered by all forces. These efforts will require appropriate resourcing by central government.

8. **NHS England and NHS Wales** should consider a further large-scale independent evaluation of liaison and diversion services across England and Wales to assess their current effectiveness and to identify what areas of the programme could be improved to better support those with vulnerabilities.

9. **Individual forces should consider how data on apparent post-custody suicides can be improved**. This could include assessing whether reported data accurately reflects deaths which occur later than 48 hours after release. There should be a review of what support and advice was offered to a person who subsequently took their own life.

10. **Relevant policing, health and local authority partners should work together to standardise aspects of pre-release risk assessments conducted to identify vulnerabilities and in particular indicators of increased suicide risk**, with follow-ups put in place where a risk is identified.

11. **Individual forces should evaluate and apply interventions to support the reduction of post-custody suicides**, with learning and good practice shared with police in other geographical areas.

Embedding learning

12. **Individual forces, with the College of Policing, should identify and share the mechanisms they use for acting on learning after a death.** This could involve a more standardised, consistent approach, and the distilling and sharing of relevant coroners' or Independent Office for Police Conduct (IOPC) reports routinely with staff across all force areas.

13. **The College of Policing should ensure that training for custody officers and their Authorised Professional Practice (APP) for custody is regularly reviewed and kept up to date, having considered any learning and recommendations following custody deaths.** The College of Policing should be responsible for ensuring this material is circulated and provided to staff consistently across all forces.

14. **Individual forces, the IOPC, the National Police Chiefs Council, the College of Policing, and any other relevant parties to an incident relating to a death should take steps to ensure emerging learning from deaths is shared as a priority following an incident, including with the Home Office and Policing Minister.** While this is not always possible for legal reasons, it is difficult for forces to respond quickly to embed learning if updates from an investigation are provided months or years after a death. It also undermines the potential for national learning.

15. **Individual forces should integrate the views and perspectives of bereaved families into their processes for learning from a death**, and ensure steps taken in response are communicated clearly and respectfully to families during and after implementation.

16. **Individual forces and the IOPC should explore how to define and record 'near miss' incidents and their investigation.** Data on, and findings from, near misses should then be collated and shared to inform learning and training to avoid such incidents in the future. A shared review on a death prevented can assist in the prevention of other deaths.

17. **The IOPC and the Home Office should work to provide further information about deaths that are currently recorded under the general classification of 'other deaths following police contact', particularly providing key details regarding themes and learning taken from these deaths.** This would improve transparency and understanding and help to reduce such deaths.

18. **Individual forces should take steps to ensure a proactive learning approach when responding to lessons following a death or near miss**. This could involve an independent facilitator in lessons-learned exercises after a critical incident in custody. This could provide unbiased insight and prompt useful internal reflection.

19. **Individual forces should make use of national seminars to share and discuss best practice**. These could be focused on specific topics and be organised in conjunction with other stakeholders. As described by the Durham PCC, these conferences can be held remotely for greater reach.

Overall

20. **Individual forces, the National Police Chiefs Council (NPCC), the College of Policing and PCCs should take steps to improve how they share with**

colleagues elsewhere the practice in the three thematic areas covered by this report. This exercise highlighted several innovative projects, interventions and approaches which, if tailored appropriately to local environments, could be applied or adopted by other forces across England and Wales.

21. **Individual forces, the Home Office, the NPCC, the IOPC and the College of Policing should take active steps to build and disseminate a greater understanding of the role of disproportionality and race in relation to deaths in police custody, particularly through the creation and dissemination of more data.** A significant number of individuals come through custody, but little data on disproportionality is collected on what happens while they are detained (such as the use of restraint, strip searches, or length of detention).[17]

22. **PCCs should lead local scrutiny panels and expand their focus to include the examination of data relating to custody performance**. These panels could focus on data relating to disproportionality, as well as mental health and substance misuse prevalence.

23. **Individual forces must prioritise safety within the broader culture of custody suites.** This includes placing emphasis on keeping people safe in custody and looking after them properly with compassion and dignity, as set out by the *Good Police Custody* guide and the relevant PACE Codes of Practice.[18]

24. **Police and Crime Commissioners should appoint a Portfolio Lead for the prevention of deaths in custody and apparent post-custody suicides.** This individual should work alongside the Policing Minister, the police and the IAPDC to drive forward work to reduce the number of deaths in custody and help to promote good practice across England and Wales. Police and Crime Commissioners should meet bereaved families as part of this role.

25. **Police custody healthcare teams, liaison and diversion services, NHS England and NHS Wales should take an integrated approach to facilitating the treatment of detainees**, especially given evidence of co-morbidity and the prevalence of drug and alcohol misuse together with mental health conditions in police custody deaths. This should involve working more closely with Integrated Care Boards whose purpose is to facilitate more collaborative working across the health and care system. To provide greater operational clarity as to the roles and responsibilities of the relevant bodies, and to identify opportunities to enhance cooperation, an overarching Memorandum of Understanding should be drawn up between police forces, prison custody healthcare, liaison and diversion teams, and substance misuse service providers, with oversight provided by a local governance forum established for this purpose.

[17] In March 2021 the then Home Secretary wrote to Chief Constables notifying forces that 16 measures relating to custody would be included in recorded Home Office data for the 2021/2022 year. These will be broken down by age, gender, ethnicity and offence type.

[18] Dr Layla Skinns and Dr Angela Sorsby, *Good police custody: Dignity, equal worth, autonomy, decency and legality*, October 2019. Available at: Good-police-custody-study-recommendations-for-practice-October-2019-final.pdf (sheffield.ac.uk).

Analysis of responses from Police and Crime Commissioners and Chief Constables

Leadership and prioritisation

23. In their responses, a number of PCCs and Chief Constables set out ways in which forces are leading the drive to prevent deaths at point of arrest and during and after police custody. Some referred to being clear about what matters most; others to developing structures to underpin priorities. In Staffordshire there is an established Mental Health and Community Safety Strategy Board chaired by the PCC to plan and oversee services for people with mental health needs who come into contact with the criminal justice system. In Nottinghamshire, the police have developed a system of performance management overseen by a chief inspector to monitor implementation of recommendations made by His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and IOPC locally and nationally and coroners' recommendations made in preventing future deaths reports.

"Protecting the vulnerable has always been central to the ethos and activity of Devon and Cornwall Police and a consistent theme that underlies our vision and priorities. We have recently established a dedicated Vulnerability Command under the leadership of a chief superintendent drawing in custody and criminal justice, each of the 13 strands of safeguarding improvement activity and mental health and suicide prevention."
– Devon and Cornwall

Mental health and risk

24. Of the 11 people who died in 2021/22 in or following police custody, six had mental health concerns and nine had links to drugs and/or alcohol. Additionally, out of the 56 apparent suicides following police custody, over three-quarters of the people (44) had known mental health needs.[19] Of these, two had been detained under Section 136 of the Mental Health Act 1983, the emergency power police use to detain someone for their own safety under the Mental Health Act.[20] Of the 11, 4 had some force used against them either by officers or members of the public before their deaths, though the use of restraint, or other types of force, did not necessarily contribute directly to their deaths. The latest statistics for the use of section 136 place the number of detentions at 36,594, an 8.7% increase on last year.[21] While only 0.8% of these involved the person in crisis being taken into police custody as a 'place of safety', this is double the numbers for last year, suggesting that more needs to be done to ensure the proposed ban on this practice in the draft Mental Health Bill can be realised.

25. Several responses outlined how the pandemic has brought new challenges to mental health provision. A sharp increase in court backlogs during and since the COVID-19 pandemic has meant that detainees are often spending longer in custody. The pandemic has also impacted front line services, including space, transport and bed availability.

[19] Independent Office for Police Conduct, 'IOPC publishes figures on death during or following police contact for 2021/22', 28 September 2022. Available at: https://policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-202122.
[20] Mental Health Act 1983, Section 136, 5 May 2022. Available at: https://www.legislation.gov.uk/ukpga/1983/20/section/136.
[21] Home Office, *Police powers and procedures: Other PACE powers, England and Wales, year ending 31 March 2022*, 17 November 2022. Available at: Police powers and procedures: Other PACE powers, England and Wales, year ending 31 March 2022 - GOV.UK (www.gov.uk). See also Home Office, *Police powers and procedures: Other PACE powers, England and Wales, year ending 31 March 2021*, 14 December 2021. Available at: Police powers and procedures: Other PACE powers, England and Wales, year ending 31 March 2021 - GOV.UK (www.gov.uk).

26. Most respondents outlined a clear approach to early intervention and multi-agency partnership working to assist with members of the public who might be experiencing a mental health crisis. PCCs set out two main systems involved in the process of responding to an individual in crisis:

    a. **Street triage** is a collaborative approach between the police and mental health services which aims to improve the response to an individual in crisis. It involves assessments as to whether a person should be held under Section 136 of the Mental Health Act and, if not, what follow-up is needed from services in the community. Street triage can take different forms between forces. For example, support from a mental health professional can be relayed from a control room (such as in Devon and Cornwall), while in other forces (such as Leicestershire and Hampshire) mental health response vehicles transport a mental health worker with another emergency worker (such as a police officer or paramedic) to the incident. At the National Custody Forum in 2022, Norfolk and Suffolk police described how their force, at the point of arrest, ensures that officers communicate with the custody sergeant to conduct a triage assessment. Where suspected offending is low-level and related to mental health issues, they may decide to take no further action and refer the individual to mental health support. In addition, they ensure such decisions are kept under review by requiring the completion of an online form to record the rationale for the use of triage, which is then reviewed by the inspector for the custody suite and approved by the Head of Custody. A 2018 study on street triage in England demonstrated that police officers are widely supportive of the scheme and would advocate a 24/7 service but that, at the time of the study, only 11% of the surveyed forces offered it.[22] We understand an evaluation toolkit developed by the College of Policing and the University of Nottingham to support forces to evaluate their street triage schemes is now in use.

"We have a Mental Health triage car on duty at key demand times and this assists officers on the street with decision making and ensuring that detainees are taken to the appropriate place based on assessments at the scene and medical records available."

– Leicestershire

    b. The use of liaison and diversion (L&D) teams is frequently mentioned throughout the responses. These are trained healthcare professionals (sometimes referred to as 'trusted assessors') who are based in custody suites and provide support by proactively screening for vulnerable individuals in custody. They provide clinical oversight, undertake assessments and, where needed, make referrals into local services, give staff training to officers and, in some cases, provide post-custody follow-up. Mental health support is often delivered through standalone L&D teams but can also be provided from separate embedded healthcare teams based in custody suites. These healthcare providers can be established through partnership with the NHS or private companies (for example with Mitie in Sussex) or the NHS. The recent criminal justice joint inspectorate report into mental health

[22] Kirubarajan, A. et al. *Street triage services in England: service models, national provision and the opinions of police*. 2018. *BJPsych bulletin*, *42*(6), 253–257. https://doi.org/10.1192/bjb.2018.62.

found that all forces had commissioned services which included an L&D service within police custody.[23]

"In support of crisis intervention and the earliest appropriate advice to officers and staff, Street Triage is embedded in our control rooms where a mental health professional is collocated with access to mental health records, care plans and pathways."
– Devon and Cornwall

27. PCCs are unanimous in the view that police custody is not a suitable location for someone who is experiencing a mental health crisis and that it should not be used as a place of safety for those under Section 136. Early interventions such as street triage should identify people requiring mental health support and divert them through immediate intervention or, if necessary, such as in a case of Acute Behavioural Disturbance (ABD),[24] convey them to a hospital by an ambulance as a priority call-out. For the latter, as the Norfolk PCC states, only in circumstances where the level of risk of harm through violent conduct would be unmanageable in hospital should a detainee assessed for hospital be transported to custody. Good practice examples were reported by Gloucestershire and Cleveland PCCs, where forces are able to provide an out-of-hours triage service, specifically for those experiencing mental health concerns. The recent mental health thematic noted that the availability of 'place of safety beds' had improved or was improving across most forces, with police facilities only being used as a place of safety in exceptional circumstances.

28. PCCs highlighted a number of apparent successes in this area. For example, Hampshire has witnessed, as a result of strong partnerships with health and social care, a reduction in police deployments to calls concerning poor mental health, which goes against the national trend. Additionally, Nottinghamshire comment that they have not used custody as a place of safety since March 2019, whilst Durham state it has only been used four times in as many years. At the National Custody Forum in 2022, the Police Service of Northern Ireland (PSNI) noted that their biggest custody suite has a dedicated mental health nurse located within it. While they worked to a 12-hour shift each day, rather than on a 24-hour basis, the PSNI described the system as making a "massive difference".

29. While the rollout of mental health response vehicles and greater use of custody-based L&D teams are both part of the NHS Long Term Plan, PCC responses demonstrate an awareness that improvements can be made locally in the short term.[25] While most PCCs have dedicated medical nursing staff providing care 24 hours a day, seven days a week, this is not replicated through custody-based mental health provision. Devon and Cornwall (8am to 6pm), Northumbria (7am to 7pm) and North Yorkshire (8am to 8pm) are examples where custody-based mental health provision through L&D teams is only available for a 12-hour (or less) window, meaning some suites are not staffed to account for any emergencies which occur at night. In the absence of L&D practitioners, nurses or medical practitioners must decide whether an out-of-hours Approved Mental Health Professional should be called to conduct a mental health assessment. Naturally, this will add time to a distressing period of detention for a potentially vulnerable individual.

[23] Criminal Justice Joint Inspection, Care Quality Commission & Healthcare Inspectorate Wales, *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders,* November 2021. Available at: https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf.
[24] Royal College of Psychiatrists, '*Acute behavioural disturbance' and 'excited delirium'*, September 2022. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_22.pdf
[25] National Health Service, *The NHS Long Term Plan*, January 2019. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf.

30. The Chief Superintendent of South Yorkshire is working nationally with health colleagues on ABD. Under the authority of the NPCC Lead for Mental Health, he is looking at how Ambulance Trusts and police services respond to suspected cases. This area has received attention during recent years following the deaths of young men including Jamie Jones, Douglas Oak and Kevin Clarke.

31. In the Metropolitan Police Service, the detention team hold a 9.30am Pace Setter meeting, chaired by the senior officer on call. The meeting seeks to understand the daily challenges, especially those of vulnerable detainees. Prior to this meeting, the Public Protection Team and the Duty Officer review those in custody with mental health concerns and/or high-risk health or welfare factor to ensure there is strategic oversight and treatment pathways are considered.

32. PCCs also comment that even when an individual has been identified as requiring a transfer to hospital under Section 136, there can be difficulty obtaining a bed. Norfolk noted that even when national sweeps for beds are undertaken this can take over 24 hours, meaning that vulnerable people are often left in the care of staff who are not trained to be dealing with a mental health crisis.

33. North Yorkshire indicated that their provision of health-based places of safety has reduced from four locations to two, with one of these only having a single bed. This means vulnerable detainees must often be transported significant distances in order to access appropriate services.

34. The Mental Health Act states that every clinical commissioning group must ensure inpatient facilities are available for urgent admission. However, a lack of beds and alternative options to hospitals can mean that placements are not always found or are found long distances away. This can be traumatic for the individual and their families. The onus for finding a bed should be with the clinical commissioners but, in reality, it is often left to be solved by frontline police officers.

35. Police forces including Devon and Cornwall have developed a more appropriate 'safe space' facility for use by young people and those with significant vulnerabilities such as mental health concerns. This space, located in Exeter, has dedicated staff and has been designed to reduce anxiety in a supportive environment.

36. During the National Custody Forum in 2022, Sussex police highlighted their use of 'wellbeing dogs' within their custody suites. These were described as being beneficial for the mental wellbeing of those held in custody, particularly in dealing with those suffering from anxiety or where de-escalation is needed. Surrey police also highlighted their similar use of what they called 'Oscar Kilo dogs' within custody suites.

37. In South Wales, the Women's Pathfinder Scheme, launched in 2019, provides targeted support for female offenders. It is a whole-system approach for those with underlying issues such as alcohol and substance misuse, mental health problems and difficult family relationships. The scheme aims to reduce the number of women in the criminal justice system, helping them to live safer, healthier lives. Likewise, the specialist substance misuse service, the Dyfodol Scheme, offers individuals a drug education programme as an alternative to a fine or court appearance.

38. To assist engagement, West Mercia are developing work to become a trauma informed organisation, changing the focus from *"what is wrong with you?"* to *"what has happened to you?"*

39. PCC submissions covered increased safety in police custody suites themselves. There was widescale recognition of the important role of Independent Custody Visitors and

reference made to the Independent Custody Observers Pilot. This has enabled custody visiting schemes to uncover concerns for the first time, such as reviews not happening on schedule or failures to identify vulnerability, which has a direct link with deaths in custody. A number of forces had invested in life-signs monitoring equipment to supplement close observation by trained staff and help to inform professional judgment about steps to take to keep people safe. Some PCCs commented that the physical state of custody suites is not a therapeutic or positive environment for those in a crisis. Among others, Nottinghamshire, Gloucestershire, Humberside and Hampshire drew attention to their refurbishment and improved designs for their custody suites. During the National Custody Forum in 2022, a representative of the College of Policing drew the IAPDC's attention to the increased use of CCTV cameras in new designs for custody suites, providing heightened observation and safeguarding for those held in custody.

40. Avon and Somerset currently run a project in partnership with the Centre for Applied Autism Research at the University of Bath. They are actively working to develop a culture that ensures detainees leave custody in a better position than when they arrived. Access is provided to a Mental Health Nurse, a Health Care Professional and a Drug and Alcohol worker. To provide further provision, there are plans to introduce Samaritans and Homeless Support Workers. They also note that alterations to physical surroundings have a wider, beneficial effect for individuals passing through custody facilities. These include painting cells to muted tones and replacing lighting so that it can be adjusted for colour, warmth and brightness.

41. HMICFRS remarked in its latest *State of Policing* report that some forces had received effective advice and help from mental health professionals, allowing police officers to deal with incidents, and, where possible, avoid detaining people under section 136.[26] Instead, they found alternative ways of providing the appropriate support for individuals in need. The report also noted that:

"In forces where help from mental health professionals wasn't so readily available, officers told us they were more likely to detain a person under section 136 and take them to a mental health facility. They said they needed to do this to manage the risks that the person posed to himself, herself or others."

Apparent post-custody suicides

42. While the issue of apparent suicides following release has gained more attention in the media and academia in recent years, it continues to receive less focus than deaths which occur in custody and is unlikely to yet be at the forefront of the minds of officers in busy custody suites. Existing research in this area has produced evidence of crucial gaps in services. Recommendations include the need for greater awareness and training for frontline staff and the need to acknowledge the trauma of detention for those suspected of, or charged with, specific offences.[27]

43. The majority of respondents outlined that detainees are assessed while in custody, where their current mental health and circumstances are reviewed, and any concerns flagged. Where L&D teams are available, practitioners visit cells to identify individuals who might be vulnerable. Independent Custody Visitors assist with identifying potential vulnerabilities which are then flagged to custody staff. This was raised as a positive intervention in a number of responses, including from Essex. In North Yorkshire, use of

[26] HMICFRS, *State of Policing – the Annual Assessment of Policing in England and Wales 2021,* 2022. Available at: State of Policing 2021 (justiceinspectorates.gov.uk).
[27] Jake Phillips, Loraine Gelsthorpe, Nicola Padfield and Sarah Buckingham, *Non-natural deaths following prison and police custody: Data and practice issues*, February 2017. Available at: https://www.equalityhumanrights.com/sites/default/files/non-natural_deaths_following_prison_and_police_custody_2.pdf.

the 'Niche' software, used for the booking-in and pre-release process, means that, where appropriate, measures can then be taken to ensure particular individuals are safe:

"As a Niche user, North Yorkshire Police follow a highly structured booking in and pre-release process that is fully documented and sets out and supports custody staff in undertaking assessments, ensuring consistency and that necessary safeguarding is put in place. This not only informs the care plan for the detainee whilst in custody (number/frequency of observations, medical care, etc), but also the conditions of release, for example that they are released into appropriate safety (e.g. to next of kin) or provided with information on or direct referral into additional support services."
– *North Yorkshire*

44. Staff in some areas are given training on identified trends and research findings showing which groups and individuals are particularly at risk. These can include individuals who have been arrested for a sex offence, people who are homeless or detainees who have previously served in the armed forces. For this last group, there were several positive mentions of Project Nova, a support charity for former members of the armed forces, and targeted support for veterans and their families. Notably, dedicated vulnerability training is being rolled out as part of a national training syllabus led by the NPCC, in collaboration with the College of Policing, in response to the joint mental health report by HMICFRS.[28]

45. Specific examples of police practice for immediate support both during and after custody include:

    a. L&D teams in Northumbria assess detainees when in custody and provide follow-up support up to 12 weeks after release if required. A restructuring of the custody model in 2015 saw the introduction of Health Care Practitioners (HCP) and Criminal Justice Liaison and Diversion (CJLD). The service, when available, ensures that all detainees are visited by a mental health practitioner prior to release. Regular meetings are held between the custody Senior Management Team and CJLD where *"performance is monitored, incidents of note reviewed and learning shared"*. This also includes the appointment of mental health leads who ensure that learning can be shared more widely and beyond the custody environment. HMICFRS stated that *"mental health liaison and diversion services were very good and valued by custody staff and detainees. The embedded service... included an impressive range of outreach and innovative post release follow up work."*[29]

    b. Nottinghamshire Police L&D services also attend to practicalities and make sure that people have safe transport home following release, and where possible contact family or friends to provide support and offer suitable clothing to people arrested in their nightwear.

"Liaison and diversion will make post release arrangements for detainees suffering with their mental health; this includes referrals to GP and contact by the community mental health team."
– *Nottinghamshire*

    c. In addition to post-custody treatment, the Paedophile Online Investigation Team (POLIT) in Nottinghamshire includes a follow-up care plan to provide contact

[28] HMICFRS, *State of Policing – the Annual Assessment of Policing in England and Wales 2021,* 2022. Available at: State of Policing 2021 (justiceinspectorates.gov.uk).
[29] HM Inspectorate of Prisons & HMICFRS, *Report on an unannounced inspection visit to police custody suites in Northumbria,* September 2019. Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/01/Northumbria-police-web-2019.pdf.

within 24 to 48 hours of release from custody, as well as a joint pre-release assessment with police and L&D teams. In Northamptonshire L&D services draw-up a follow-up within 24 to 48 hours after release and referral, if needed, to the Lucy Faithful Foundation, a child protection charity dedicated to preventing child sex abuse.

d. The Metropolitan Police Service has a joint cooperation agreement with the Mayor's Office for Policing and Crime (MOPAC) which is a database of support referral organisations and agencies that is available online and on release via a QR code to sign-post to services that offer mental health support. This is offered to all detainees and sets out referral and support organisations including mental health support.

e. Devon and Cornwall raised the issue of isolation, which can be caused when a detainee has had their mobile phone seized for evidence. Where the isolation may increase the risk of suicide, a basic mobile phone (with a pre-loaded SIM allowance) is loaned to them. This enables people to reach out or be available to a mental health professional in the days and weeks after release from custody.

f. In Surrey, all detention officers are required to complete a pre-release risk assessment which is also used from the moment an individual arrives in custody, resulting in a live document that is regularly updated throughout the detainee's stay. This approach ensures that information is not missed, and the conditions of a particular detainee's release are safe and appropriate to that individual. The PCC noted that they would like to see the Niche system adapted to reflect this approach.

g. In Cambridge and Peterborough, a suicide strategy is developed and carried out for at risk individuals, the majority of which have been arrested for sexual offences. Any concerns raised by the investigator would form part of the considerations when building the strategy. This includes signposting to support services, ensuring they are collected by family and provided with support outside of custody. An officer would also make regular contact to check on the welfare of the detainee post release.

h. Dyfed-Powys was one of five areas to take part in the national Independent Custody Observers Pilot run by the Independent Custody Visitors Association (ICVA). The pilot, which commenced in September 2019, allowed ICVs to routinely review an independently selected sample of custody records of those who were identified as being most vulnerable, including young people and individuals with mental health needs.

i. Many responses identified significant efforts to signpost detainees to community services. Avon and Somerset stated that following up with community services where people have been referred is challenging and requires ongoing administrative support. Areas such as Devon and Cornwall have introduced *Pathfinder,* a flagship out-of-court disposal scheme, which looks to offer interventions tailored to an individual's needs. One cohort, for example, is composed of middle-aged veterans who live with a range of issues including alcohol misuse and post-traumatic stress disorder. *Pathfinder* engages with the armed forces, Project Nova and Combat Stress (support charities for former members of the armed forces) to facilitate access to, and engagement with, relevant services. These programmes enable veterans from the armed forces to access a range of mental health services for those with complex needs.

j. Durham distributes a product called the 'Little Blue Book' of advice and guidance to those leaving detention to be used as an aide with relevant signposting to specialist services. In South Wales, the Samaritans pay regular visits to suites over the weekend.

k. During the National Custody Forum 2022, Warwickshire police highlighted that the PCC for their area coordinates a volunteer scheme for Appropriate Adults and others within the community, whom officers call at the point of arrest and who are then available to provide support to individuals following release.

46. While good work is clearly being taken forward in this area, there appears to be minimal evaluation of which interventions are most successful. This is especially relevant concerning the interventions managed by external agencies. In addition, the signposting examples typically rely on self-help, an individual's wish to 'reach-out' for support, or a reliance on, and the availability of, supportive friends and family.

47. Only two of the responses allude to services (both L&D teams) who would make referrals for follow-up support reaching beyond a few days. North Yorkshire suggested the use of mental health support which is phased to help an individual integrate back into the community after having been detained, though regretted the lack of funding available for such a provision.

48. The joint mental health thematic action plan from DHSC, the Ministry of Justice (MoJ) and the Home Office in response to the joint inspection on mental health across the criminal justice system states that there are continued local partnership arrangements to "ensure that referral pathways are made available for persons detained in custody and upon release via the post-release risk management process."[30]

"Respite mental health care provision would be an excellent way to ensure that detainees leaving custody could have a phased return where there are concerns for their welfare or mental condition. This is not a service that exists currently and would require funding."
– North Yorkshire

Embedding learning

49. Gathering, implementing and disseminating learning is vital to avoiding repeat deaths. Bereaved families regularly make clear their wish that no other family should go through the same experience as they have and the hope that future deaths will be prevented. PCC responses suggested there are challenges which need to be overcome around quickly and clearly sharing and embedding learning from a death across police forces, which are all operationally independent from one another.

50. Each PCC response noted a dedicated effort to local learning made in response to specific incidents or patterns. Specific examples include:

a. The Governance and Development team in Cleveland host a quarterly masterclass to ensure 'gold standard practice' from outcomes of coroner's investigations into deaths in custody. They also ensure that extended courses around substance misuse and alcohol dependence are available for all staff. A dedicated training manager working within the force ensures that training needs are identified early, and support is given.

[30] HMPPS, MoJ, DHSC, HMCTS, HO, Welsh Government, NPCC, CPS & NHS England, *A Response to: A Joint Thematic Inspection of the Criminal Justice Journey for Individuals with Mental Health needs and Disorders*, 4 March 2022. Available at: Joint_Thematic_Action_Plan__Final_.pdf (publishing.service.gov.uk).

b. Some forces, including in Northumbria, detail robust quality assurance programmes with learning identified from reviewing custody interventions, accidents and near-misses. The evaluation process also includes key feedback from stakeholders, individual cases' detainee complaints and recommendations from the IOPC.

c. Responses referenced the use of bulletins which are sent out to staff and in some areas used in debriefs on recent concerns. In South Yorkshire, written bulletins are available to staff in the form of a regular newsletter following an investigation. Some forces, such as Hampshire, produce a monthly document highlighting 'key topics' that acts as a reference source of information against which progress is measured by a central team.

d. Any national circular updating on IOPC recommendations and learning around Deaths and Serious Injuries (DSIs) are shared with staff in the custody staff newsletter in Cheshire.

e. A network of Public Protection Champions operates in each detention suite in the Metropolitan Police Service. These volunteers disseminate key monthly messages, lessons learned or general best practice on safeguarding issues – including mental health.

f. Other forces indicated that bulletins or reviews are discussed at a more senior level, with information then being filtered down to custody officers. In North Yorkshire this is done via the force's local intranet.

"SYP [South Yorkshire Police] aims to capture lessons learnt at the end of any investigation (Independent Office for Police Conduct (IOPC) or internal). These are shared with the Force's Professional Standards Department Champions, circulated in supervisors' briefings and will soon be included in an engagement newsletter."
– South Yorkshire

g. In Nottinghamshire, all adverse incidents are reviewed and escalated to regional Senior Management Team meetings, where learning and good practice is reviewed. There is also a dedicated inspector in custody who oversees near-misses and reviews these for trends and patterns.

h. In Sussex, the Mitie Healthcare Care & Custody team regularly undertake lessons learned training at a monthly Local Clinical Governance Meeting (LCGM), where electronic incident reporting is reviewed and published for dissemination to ensure continuous improvement.

i. In West Mercia, when 'near-misses' occur they are reviewed by the Professional Standards Department in order to 'establish if they meet the Death or Serious Injury criteria'. The learning is captured and fed back to the head of custody.

j. The Metropolitan Police Service has a system where incidents are recorded and investigated to understand why the incident occurred and what lessons can be learned. These are then discussed at weekly and quarterly meetings by the Senior Leadership Team lead for Health & Safety and Mental Health.

k. In 2019, the National Police Estates Group (NPEG), have launched an initiative with the College of Policing called the Custody Review Panel (CRP), a peer review system for custody projects. This enables professionals with custody-related experience to review a force's design proposals and finished builds. According to the NPEG:

"This has resulted in significant and cost-effective design amendments, which further de-risk the police custody estate."
– National Police Estates Group

51. Some examples were provided of where previous incidents have led to change:

    a. In Devon and Cornwall, the removal of *"family jewellery or a particular item of clothing"* from detainees has been halted to avoid distress.

    b. Following a death in custody in 2016 and a report by the coroner, Northumbria enhanced its risk assessment to include safeguards for when a detainee is unable or unwilling to co-operate with the process.

52. In addition, PCCs detailed a variety of ways staff receive mandatory training to ensure access to the latest good practice. Responses suggested varying levels of training for custody staff, from bi-annual exercises to five-week intensive sessions.

    a. Gloucestershire referenced regular Authorised Professional Practice (APP) training which is produced by the College of Policing and conducted twice a year to upskill custody sergeants.

    b. In Leicestershire, when custody sergeants begin initial training, mental health is embedded in the syllabus, as well as shadowing experienced sergeants. Similarly, in Nottinghamshire, officers and custody staff are required to undergo an intensive five-week training programme provided by L&D teams on mental health pathways.

"When custody sergeants are given their initial training they are also given an input on Mental Health within this syllabus. A newly trained sergeant would also spend time in company with an experienced sergeant that also assists with embedding learning."
– Leicestershire

    c. In Norfolk, a training programme is delivered to front-line staff to support an improved response to those suffering a mental health crisis.

    d. During the National Custody Forum in 2022, Surrey police expressed pride at their training department for those working in custody suites, stating that they also undertake training for other forces' custody officers.

53. The College of Policing has also devised an 'immersive' custody training package, using a 'Hydra' simulation centre, which it is launching for custody sergeants and detention officers across the country.[31] At the National Custody Forum in 2022, the Chair of the IAPDC was told that almost all 43 police forces across the country have signed up for this training, and that it has been supported by all Chief Constables, providing a strong mandate for forces to require the training among its custody officers. The training was described as having been introduced in response to the calls to improve standards within custody suites following the Angiolini review. The Panel is very interested to see this training being launched and would hope to see evidence of its impact once it has had time to become fully established.

54. PCCs flagged examples where forces had hosted national seminars in order to share learning: a national conference on Acute Behavioural Disorder hosted by South

[31] Information available at: https://www.college.police.uk/article/custody-immersive-learning-package and https://collegeofpolicing-newsroom.prgloo.com/news/college-of-policing-launches-new-immersive-training-to-improve-safety-in-custody.

Yorkshire Police in 2018 and an online seminar hosted jointly by Durham Police and King's College on drugs and alcohol this year. The use of remote seminars held online can ensure learning on specific topics reaches a wider audience and overcome geographical restrictions.

55. There was minimal discussion of the communication of lessons learned from deaths across different forces, which can be challenging due to operational independence. Some used their own intranet sites to disseminate local learning, though a mechanism for wider knowledge sharing would be welcomed. Of note was a response from North Yorkshire which indicated that a "blame culture" still exists in how police deal with near misses and deaths. This contrasts with other areas of emergency work, most notably health.

56. There were almost no references to the role of bereaved families as part of stated processes to embed learning following a death. This was an important omission. Involvement of family members can aid learning and improve accountability, as well as encourage services to implement recommendations made to prevent future deaths. Best practice needs to be developed with the active involvement of bereaved families and those who support them.

Protecting lives: other information offered

57. Responding PCCs also offered examples of police practice in protecting lives which fell outside of the three key themes.

58. Some PCCs drew attention to neurodiversity and the importance of understanding and responding to particular needs and vulnerabilities. Durham outlined its commitment to a *'Making Every Adult Matter'* pilot which is being developed with partners in the local area alongside a place-based approach to managing vulnerability, high intensity service users with multiple complex needs, and anti-social behaviour. Northumbria is also adopting a similar approach, having found staff knowledge gaps in relation to identifying autism and other neuro-diverse needs, to help ensure staff are properly trained in working with people with neuro-divergent conditions.

59. The model 'Right Care, Right Person' programme from Humberside considers, at the outset of an incident relating to concern for welfare and physical and/or mental health, who the right person or agency is to respond (rather than the police just responding automatically as they would have done). The right respondent will have the right skills, training, and experience for the situation. As a result, the force has seen a significant reduction in the number of deployments to these types of incidents.

60. West Midlands police forces work closely with its Violence Reduction Unit and Barnardo's to deliver a trauma-informed custody action plan. This aims to identify initiatives that reduce trauma and ensure people remain healthy during and after custody. Their Police and Crime plan references commitments to this by exploring how their new custody provision can better meet the needs of children and young people in custody, potentially by offering specialist police facilities that offer integrated, intensive support and diversion opportunities.

61. Others raised concerns and offered good practice examples relating to dealing with drug and alcohol misuse. PCC responses suggested more help with funding for alcohol and drug practitioners to increase their availability in addition to widening the ICV schemes, which would allow for more trained volunteers to assess for vulnerabilities. Dyfed-Powys Police, in partnership with the Hywel Dda Health Board have developed a procedure to manage the safer detention of, and gathering evidence from, individuals who chose to

conceal drugs. Dyfed-Powys and West Yorkshire, among others, advocated the use of Naloxone, a treatment to reverse the impact of opioid overdose.

62. The provision of Appropriate Adults was highlighted by the Essex PCC, who stated that the area's use of the scheme had received praise from ICVs. However, they outlined that such an initiative requires more funding to achieve its potential. The HMICFRS annual report stated that they "found some forces were better at arranging for an appropriate adult to support children and vulnerable adults. There were still some long waits for appropriate adults to arrive at custody suites, but more forces were arranging for this support to be provided much earlier in individuals' detention".[32]

63. Dorset applies a multi-agency approach to suicide prevention, led by the British Transport Police, with a focus on location-based risk assessment with the support of key stakeholders. Dedicated, trained staff are located in specific train stations deemed high risk areas.

64. The Association of Police and Crime Commissioners indicated that they recommend, and support calls for, bereaved families to receive legal aid support following a death in custody.

65. Concerns about protecting staff in closed custodial environments during the pandemic were raised at the National Custody Forum in June 2021. From December 2020, the IAPDC, amongst others, advised that a universal approach be taken to vaccination of all staff and everyone detained in closed institutions.[33] These challenges were also detailed in written PCC responses:

"It shouldn't be underestimated the impact that COVID-19 has had on the police officers and staff in our custody areas in such challenging circumstances and the absence of a specific government vaccination programme for these personnel."
– West Yorkshire

Next steps

66. The IAPDC will discuss these findings and recommendations **(see page 7)**, and how good practice examples can be shared, with Police and Crime Commissioners, Chief Constables and their colleagues, policing associations, the College of Policing, the National Police Chiefs Council, HMICFRS, IOPC, NHS England, and DHSC.

67. Co-chaired by Ministers from the MoJ, Home Office, and DHSC, the Ministerial Board on Deaths in Custody will continue to focus on response to mental health need and improving engagement with families to prevent future deaths in custody. Board co-chairs for Policing and Health and the Independent Advisory Panel on Deaths in Custody will meet to discuss dissemination of findings and implementation of recommendations to protect lives. The objective is to deliver meaningful and lasting change to prevent deaths in police custody.

[32] HMICFRS, *State of Policing – the Annual Assessment of Policing in England and Wales 2021,* 2022. Available at: State of Policing 2021 (justiceinspectorates.gov.uk).
[33] See universal vaccination correspondence on the IAPDC's COVID-19 Hub. Accessible at: COVID-19 Hub — Independent Advisory Panel on Deaths in Custody (iapondeathsincustody.org).

Annex A:

Methods and information-gathering exercise

Early in 2021 the Independent Advisory Panel on Deaths in Custody (IAPDC) and the then-Policing Minister the Rt Hon Kit Malthouse MP agreed to work together as a matter of priority to prevent deaths at the point of arrest, in police custody and following release. The resulting police leadership initiative was announced at a meeting of the Ministerial Board on Deaths in Custody. It would begin with a major information gathering exercise across police forces in England and Wales and lead to dissemination of good practice.

In February 2021 the then-Policing Minister and Juliet Lyon CBE, Chair of the IAPDC sent a joint letter to all Police and Crime Commissioners (PCCs) in England and Wales.[34] The letter recognised some areas of progress made in response to the recommendations by Dame Elish Angiolini KC in her review into deaths and serious incidents in police custody. The letter asked for good local practice examples on how forces work to prevent, or respond to and learn from, deaths.[35]

Between March and April 2021, we were grateful to receive a total of 20 responses from a possible 43 force areas, in addition to three associated organisations and representative bodies (Annex B). **While this represents a substantial return, we were aware that the responses did not constitute a fully representative picture across England and Wales** and indeed did not include some of the largest forces in the country.

In the second phase of this initiative, the then-Policing Minister and the IAPDC Chair invited further contributions – both to update earlier information and to develop and share a more complete picture of work by forces to prevent deaths in custody.

We were grateful to receive an additional seven responses, including from some of the larger police forces, between November 2021 and January 2022. Responses have been taken in good faith and not verified with the senders, while further progress may also have occurred since submissions were made.

During the research period, the panel discussed interim findings and updates with the then Policing and Health Ministers. The chair of the panel, Juliet Lyon, was also grateful to be able to attend a meeting convened between the Rt Hon Kit Malthouse MP and Gillian Keegan MP, John Oak, father of Douglas Oak who died in police custody, and former panel member, Dr Meng Aw-Yong. This was an opportunity to discuss the importance of mental health response, timely ambulance services, and police training.

In September 2022, the Chair of the IAPDC, Juliet Lyon, spoke at the National Custody Forum about this project. She gave delegates attending the forum the opportunity to highlight further good practice from their forces, as well as the challenges they face in tackling these issues. Examples of good practice identified via the Forum have been included in this report.

Alongside the information gathering exercise, the Panel convened further meetings with key stakeholders, such as members of the College of Policing, to discuss interim findings and emerging recommendations and building the evidence base for the Panel's work.

[34] The Rt Hon Kit Malthouse MP and Juliet Lyon CBE, *Letter to Police and Crime Commissioners,* 18 February 2021. Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/60a38f2341ce147183647e5e/1621331747884/Letter+from+the+Crime+and+Policing+Minister+and+Juliet+Lyon+CBE.pdf.

[35] The Rt Hon Dame Elish Angiolini KC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody,* January 2017. Available at: Report of the Independent Review of Deaths and Serious incidents in Police Custody (publishing.service.gov.uk).

First letter to Police and Crime Commissioners from the Rt Hon Kit Malthouse MP, then-Minister of State for Crime and Policing, and Juliet Lyon CBE, chair of the Independent Advisory Panel on Death in Custody

18 February 2021

To all Police and Crime Commissioners in England and Wales,

As Policing Minister and Co-Chair of the Ministerial Board on Deaths in Custody, I am writing together with Juliet Lyon, Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC), to seek your input on areas of work which we believe, if collaboratively addressed, will help to prevent deaths in police custody. Ahead of the Police and Crime Commissioner elections in May this year we would be grateful for your assistance in highlighting good practice in your area and any gaps in provision you have identified.

Every death in police custody is a tragedy, and the Government is committed to delivering meaningful and lasting change to prevent such deaths. We appreciate the work that you and police forces are already doing to prevent deaths and note the low number of deaths within police custody suites. Unfortunately, however, deaths in or following police custody are still occurring. In 2019/2020 there were 18 individuals who lost their lives – a figure that has not greatly fluctuated over the last decade. The findings from the recent inquest into the sad death of Kevin Clarke in 2017 have provided a stark reminder of changes that must still be made.

We recognise the progress that has been made in response to the recommendations made by Dame Elish Angiolini in her 2017 review of deaths and serious incidents in police custody. The Government will be publishing an update in early 2021 to give further detail on recommendations that have been implemented and work in progress.

We have identified the following priority areas where we believe focused attention could help prevent deaths and support bereaved families appropriately:

- **Mental health**:11 of the 18 people who died in 2019/20 in or following police custody had mental health concerns and 14 had links to drugs and/or alcohol. These high rates are consistent with long term trends. While schemes such as street triage; custody liaison and diversion; and emergency places of safety go some considerable way to ensuring those in crisis can receive appropriate treatment and support for their needs, we understand that the availability of such initiatives can be area specific. We are interested in identifying and sharing best practice where it exists. It is the IAPDC view that mental health professionals should be the first responders on the scene for those in crisis.

- **Apparent post-custody suicides:** There were 54 apparent suicides following police custody in 2019/20, a figure significantly higher than the recorded number of deaths in police custody. We believe that these figures demonstrate the urgent need for adequate pre-release assessments specifically to identify early warning signs of behaviour linked to risk of suicide, as well as custody and community-based support interventions, potentially involving the third sector. We would appreciate your views on this issue.

- **Embedding learning**: Ensuring forces learn lessons after a death in custody is vital, especially for bereaved families who repeatedly make clear their wish that no other family

should go through the same experience as they have. The Government is currently assessing how Prevention of Future Deaths reports issued by coroners are understood and responded to across custodial agencies. We continue to work closely with the Independent Office for Police Conduct (IOPC) and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) to embed lessons learned as quickly as possible after deaths or serious incidents in police custody. We would be interested to know of successful local examples of sharing learning following a death including where family members have been involved and supported.

In summary, we would welcome any examples of good, local practice in preventing deaths at point of, during and after police custody, and ensuring forces are learning from these tragic events. We would also invite your views on how the Ministerial Board and the IAPDC can assist you and police forces in this regard.

We would be most grateful if you could send your responses to iap@justice.gov.uk by 19th March. We will then re-engage with Police and Crime Commissioners to reflect on best practice and priorities to ensure that we can provide forces with the support they need to prevent future deaths.

Kit Malthouse MP
Minister of State for Crime and Policing and Co-Chair of the Ministerial Board on Deaths in Custody

Juliet Lyon CBE
Chair of the Independent Advisory Panel on Deaths in Custody

List of PCCs and colleagues who submitted a response to first letter from the Rt Hon Kit Malthouse MP and Juliet Lyon (March 2021)

All responses were written by the force's PCC / Police, Fire and Crime Commissioner (PFCC) unless otherwise stated.

1. Cleveland (Strategic Contracts & Governance Manager)
2. Devon and Cornwall (Deputy Chief Constable)
3. Durham
4. Essex
5. Gloucestershire
6. Dyfed-Powys
7. Hampshire & Isle of Wight (Chief Constable & PCC)
8. Leicestershire (PACE Custody Inspector)
9. Norfolk (co-signed by the Deputy Chief Constable)
10. Northamptonshire
11. Northumbria
12. North Yorkshire
13. Nottinghamshire (Chief Inspector)
14. South Yorkshire
15. Staffordshire (Programme Lead of Offender Management)
16. Surrey
17. Sussex
18. Thames Valley
19. West Mercia
20. West Yorkshire

Associated organisations

21. Association of Police and Crime Commissioners (Co-signed by PCCs for Dorset & Kent)
22. British Transport Police
23. National Police Estates Group (Senior Policy Advisor)

Second letter to Police and Crime Commissioners from the Rt Hon Kit Malthouse MP, then-Minister of State for Crime and Policing, and Juliet Lyon CBE, chair of the Independent Advisory Panel on Death in Custody

2nd November 2021

To all Police and Crime Commissioners in England and Wales,

As Policing Minister and Co-Chair of the Ministerial Board on Deaths in Custody (MBDC), I am writing together with Juliet Lyon CBE, Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC), to express our gratitude to those of you who responded to our request in February for examples of good practice your police force areas employ to prevent deaths in custody.

As you prepare your Police and Crime Plans for the coming years, the latest data from the Independent Office for Police Conduct (IOPC) – which showed 19 people died in or following police custody, 92 people died during or following other contact with the police, and that there were 54 apparent post-custody suicides – demonstrates an urgent need to take a zero-tolerance approach to deaths in custody. This year I met with the IOPC and the College of Policing (CoP) to discuss this strategy, and I also welcomed the opportunity to outline it at the annual National Police Custody Forum in June.

A wider summary of work taken forward to prevent deaths in, or following, police custody is outlined in the Government's recent update on progress against recommendations made in the Angiolini Review. Other work continues, including steps taken by the IOPC to produce early notifications following a death and the CoP's work to develop a National Personal Safety Curriculum training custody officers on decision-making.

In February we identified three priority areas where we believe focused attention could help to prevent deaths: responding to mental health need, support to prevent apparent post-custody suicides, and embedding learning. We asked for wider thoughts on the role of leadership, and how the Home Office and Ministerial Board on Deaths in Custody could support forces to protect lives. In the wake of findings from inquests into the deaths of Black men following the use of force, we would also like to know what efforts are being made to collate, publish and respond to data on the use of force and disproportionality. In total we received 20 responses from PCCs and a further three from associated agencies, including the Association of Police and Crime Commissioners. Returns yielded a promising range of practical local examples, positive suggestions for my department and others, and a realistic assessment of some of the key challenges remaining.

Having examined these contributions, we are pleased to share with you the IAPDC's interim report summarising the initial findings from this exercise.

Mental health: A number of PCCs outlined methods that officers employ to assist them in responding to members of the public who are experiencing a mental health crisis. Responses highlighted how positive relationships with mental health professionals – such as custody-based Liaison and Diversion (L&D) teams, or practitioners who support first responders – are of paramount importance. It was pleasing to hear of clear leadership, committed staff and cross-agency relationships. Challenges remain in terms of forces all accessing and reaching the same high standard of mental healthcare and substance misuse treatment. There is scope for engaging families in support for relatives in difficulty or distress.

Apparent post-custody suicides: According to the latest IOPC statistics there were 54 apparent suicides which took place within 48 hours of someone being released from police

custody in 2020/21. Many PCCs outlined their awareness of the risk of self-inflicted death post release and highlighted the difficult dual role police often face as both enforcer and supporter. While risk assessments and support schemes are in operation across forces, we were concerned that many forms of support appear to rely on individuals proactively seeking help rather than involving any consistent, systematic aftercare. Exceptions to these occur in some forces, for example where L&D staff make referrals for detainees and follow-up with them in the subsequent weeks. Understanding the demographic backgrounds involved, maximising the role of charities such as the Samaritans, and establishing strong links between police, health and community providers all seem crucial in this area.

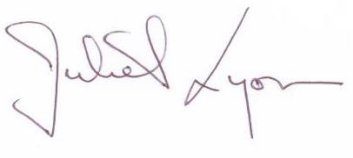
Embedding learning: Some forces appear to have robust internal methods for sharing learning following a critical incident, such as the circulation of learning bulletins and good governance mechanisms. We think more could be done – in collaboration with the Home Office, Coroners, investigatory bodies and respectfully with bereaved families – to share and embed learning promptly and across force boundaries.

Overall, the exercise revealed the continued need to place emphasis on keeping people safe in custody and looking after them properly with compassion and dignity. All forces, departments and relevant organisations need to adopt a proactive approach to sharing good practice and learning – both centrally and horizontally across forces. In that spirit, we hope the attached interim report will serve as a useful resource for all PCCs, Chief Constables, officers and relevant partners.

We encourage all PCCs and forces to reflect on some of the good practice examples and broader themes that emerge from its findings. We would now welcome your thoughts on the paper and additional ideas, particularly from those recently appointed as PCCs or those who were unable to respond to our original call. Overall, I urge you all to consider the prevention of deaths in custody and post-custody suicides as top priorities as you develop your upcoming Police and Crime Plans. We would ask for responses to be provided week commencing 22nd November 2021.

The IAPDC and MBDC will progress the work which stems from these findings, including wider sharing and profiling of identified good practice. We will engage with relevant organisations to emphasise a zero-tolerance approach to deaths in custody, which are a catastrophe not just for the individual and their family, but for the force and all relevant partners.

Kit Malthouse MP
Minister of State for Crime and Policing and Co-Chair of the Ministerial Board on Deaths in Custody



Juliet Lyon CBE
Chair of the Independent Advisory Panel on Deaths in Custody

List of PCCs and colleagues who submitted a response to second letter from the Rt Hon Kit Malthouse MP and Juliet Lyon (November 2021)

All responses were written by the force's PCC / Police, Fire and Crime Commissioner (PFCC) unless otherwise stated.

1. Avon and Somerset
2. Cambridge and Peterborough
3. Cheshire
4. Hampshire and Isle of Wight
5. Metropolitan Police
6. North Yorkshire
7. South Wales
8. West Midlands

Annex B: About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody (MCDC) formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

• Ministerial Board on Deaths in Custody
• Independent Advisory Panel (IAPDC)
• Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, an advisory non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. Drawing on research evidence and consultation with members of its practitioner and stakeholder group, experts by experience and bereaved families amongst others, the panel provides guidance on policy and good practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAPDC. The other members are:

- Jenny Talbot OBE, Prison Reform Trust
- Professor Jenny Shaw, Professor of Forensic Psychiatry, University of Manchester
- Professor Seena Fazel, Professor of Forensic Psychiatry, University of Oxford
- Deborah Coles, Director, INQUEST

John Wadham, Chair of the National Preventive Mechanism, was a member until December 2021.

Further information on the IAPDC can be found on its website: https://www.iapondeathsincustody.org.

For more information on this paper – or on the IAPDC more generally – please contact: Piers Barber (Piers.barber1@justice.gov.uk).