EMBARGOED UNTIL 00:00 2 DECEMBER 2022

Avoidable deaths in police custody: more can be done to protect lives, says independent advisory body

Police forces, Police and Crime Commissioners (PCCs), and health partners must improve practice to prevent deaths at the point of arrest, during, and after custody, a new report states, published today. The latest report by the Independent Advisory Panel on Deaths in Custody (IAPDC) for the first time brings together a wide range of policing practice across England and Wales to prevent deaths and makes a series of recommendations for police, healthcare, and other bodies.

As policing priorities are being re-examined, the report illustrates a range of initiatives identified by police themselves to prevent deaths at the point of arrest, during, or after custody. Many forces have forged partnerships with allied health and justice services to play to professional strengths, reducing inappropriate use of police time and serving to prevent deaths in custody.

But practice is not uniform across England and Wales, with limited evidence that forces are sharing findings after a death or involving bereaved families in driving change. More should be done to ensure practice is evaluated and shared, and there should be greater focus on ensuring health partners are first-responders to those in mental health crisis, not police. There remains a concerning number of apparent suicides following release, consistently greater than the number of deaths within custody itself. Despite this, there is limited evidence of police and healthcare partnerships to provide effective aftercare for people vulnerable after release.

Juliet Lyon, Chair of the IAPDC, said:

> *"Avoidable deaths are just that: 'avoidable'. Every death in police custody is a tragedy. It's clear from the submissions we received that good leadership, a structured approach, strong partnerships with health and ambulance services, and a preparedness to learn from tragedy and the experience of bereaved families can prevent future deaths."*
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> *"We will continue working with Ministers, police and crime commissioners and police chiefs to ensure that good practice is better shared and a zero-tolerance approach to deaths in custody is developed and maintained."*

The report forms part of a joint police leadership initiative with the Home Office, initially led by former Policing Minister, the Rt Hon Kit Malthouse MP, to drive forward the government's zero-tolerance approach to police custody deaths. PCCs and associated organisations were asked to share examples of good practice across three priority areas, of which the report makes a series of recommendations, including:

a) **Mental health and risk**: There should be greater collaboration across agencies, particularly healthcare, to support the mental health of people in crisis.
b) **Apparent post-custody suicides**: Individual forces, with local services, should explore options to support vulnerable people on release, particularly those at risk of suicide.
c) **Embedding learning after a death or near miss**: More must be done to share and embed learning promptly and across boundaries, particularly by learning from bereaved families, the Home Office, coroners, and investigatory bodies.

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Notes

1. Contact: Sam Johnston Hawke, Ministerial Council on Deaths in Custody (sam.johnston-hawke@justice.gov.uk). Juliet Lyon CBE, Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC), is available for further comment and/or interview.

2. The role of the IAPDC, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials, and the Ministerial Board on Deaths in Custody. 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.

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 IAPDC received 28 responses in total from PCCs and Chief Constables, and three from associated organisations.

6. The IAPDC makes 25 recommendations, addressed to police forces, PCCs, policing organisations, health trusts, ambulance associations, local authorities, and others, detailed in full below.

7. The IAPDC will discuss these findings and recommendations, and how good practice examples can be shared, with PCCs, Chief Constables and their colleagues, policing

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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 2022, 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.

associations, the College of Policing, the National Police Chiefs Council, HMICFRS, the IOPC, NHS England, and the Department of Health and Social Care (DHSC). Co-chaired by Ministers from the Ministry of Justice, Home Office, and DHSC, the Ministerial Board on Deaths in Custody is committed to focusing 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 IAPDC will meet to discuss dissemination of findings and implementation of recommendations to protect lives.

5. Full list of report recommendations:

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. 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 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 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.
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.
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.
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).

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.
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.