Association of Police and Crime Commissioners

APCC Guidance: Preventing Deaths in Police Custody and Apparent Suicides Following Release from Custody

Last Update: June 2024

This APCC guidance seeks to support Police and Crime Commissioners to fulfil their statutory duties to set local police and crime priorities; to hold Chief Constables to account; and to work in partnership in relation to preventing deaths in police custody and apparent suicides following release.

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Foreword

Emily Spurrell, APCC Mental Health & Custody joint lead and Police and Crime Commissioner for Merseyside

Police custody is an essential part of everyday policing that we must strive to get right every time. Each year, thousands of people enter police custody, many with significant vulnerabilities and multiple complex needs that require a caring and professional response.

From my experience of spending time observing police custody, I recognise just how challenging the environment can be for those officers and staff working within it. Yet, we must not lose sight of how important their commitment and professionalism is, particularly when it comes to confidence and trust in policing.

As elected representatives, Police and Crime Commissioners (PCCs) can play a key role in encouraging policing to strive for the highest standards possible. For example, PCCs are empowered by the public to deliver effective scrutiny and oversight of policing, be it through our meetings with Chief Constables, or via our Independent Custody Visitors (ICVs) who provide valuable reporting on what they observe in police custody.

Sadly, as demonstrated by recent data provided by the Independent Office for Police Conduct (IOPC) (July 2023), vulnerability often continues in the immediate period following release from custody. Under the European Convention on Human Rights and Section 6 of the Human Rights Act 1998, Police Forces have a positive duty to ensure that they have in place a system of

precautions, procedures and training that will to the greatest extent protect life, including post-custody suicides.

More can be done to assess and reduce risk, and to help vulnerable people access vital support upon release. PCCs can play a key role locally in encouraging forces and support providers to work together to reduce risk and encourage vulnerable people to access appropriate care.

As the Association of Police and Crime Commissioner's (APCC) joint lead for Mental Health & Custody, I am determined to work with colleagues and partners towards a 'zero tolerance' approach to deaths in custody. This is why I have commissioned this guidance which has been developed with incredibly helpful input from PCC colleagues across England and Wales, and the expertise of national partners including the Independent Advisory Panel on Deaths in Custody (IAPDC) and the National Police Chiefs' Council (NPCC).

I would like to thank all those who have kindly contributed to what I hope is useful guidance. Finally, I'd like to encourage readers to closely consider the advice, recommendations and practice captured within this guide and to raise it with your Chief Constables, ICV Scheme manager, and partners, with the aim of making police custody as safe as possible and ensuring the public can have the highest possible levels of confidence and trust in this unique area of policing.

Purpose

This guidance has been produced by the APCC to support the prevention of deaths in police custody and apparent suicides following release from police custody. This is aimed for PCCs; Police, Fire and Crime Commissioners; Mayoral Authorities with PCC functions (hereafter referred to as 'PCCs'), and their offices in England and Wales, referred to as the Office of the Police and Crime Commissioner (OPCC).

Whilst this guidance primarily focuses on scrutinising detainee care in custody suites, the APCC encourages PCC scrutiny throughout the entire custody journey, starting from the point of arrest and transportation to the custody suite, as there are opportunities to identify and manage vulnerabilities before arrival to the custody suite. For more information, see draft national guidance produced by the Home Office on scrutinising wider police powers.

The production of this guidance reflects the significant impact deaths in police custody can have, not only on the families of the bereaved, but also on public confidence in policing. Additionally, the guidance aims to support PCCs to satisfy national recommendations made to policing by the IAPDC in December 2022.

Within the guidance, you will find helpful resources and information, alongside useful advice, recommendations, and case studies that, where possible, are supported by evaluation and evidence. In summary, we hope this guidance will:

- **Raise awareness of the importance of preventing deaths in police custody and apparent suicides following release from custody.**

- **Enable PCCs to deliver a preventative approach by informing their scrutiny in this area.**

- **Support the successful delivery of recommendations made to PCCs/APCC by the IAPDC in their national report, 'Preventing deaths at the point of arrest, during and after police custody (2022) '**

- **Improve external understanding of the PCC role by highlighting examples of PCC led activity.**

The APCC encourages feedback on all of its resources. If you would like to share feedback on how this guidance has supported you in delivering your responsibilities or have examples you would like to be considered in updated versions of the guide, please contact the APCC (see contact us section).

Methodology

To develop guidance that is useful and evidence based, the APCC has employed a range of evidence gathering methods. This includes an evidence review of relevant literature relating to PCCs and deaths in police custody; engaging with national stakeholders such as the NPCC, Home Office, and the Independent Custody Visiting Association (ICVA); and consulting with PCCs and their offices across England and Wales to ensure the final resource is member-led and features evidence-based case studies.

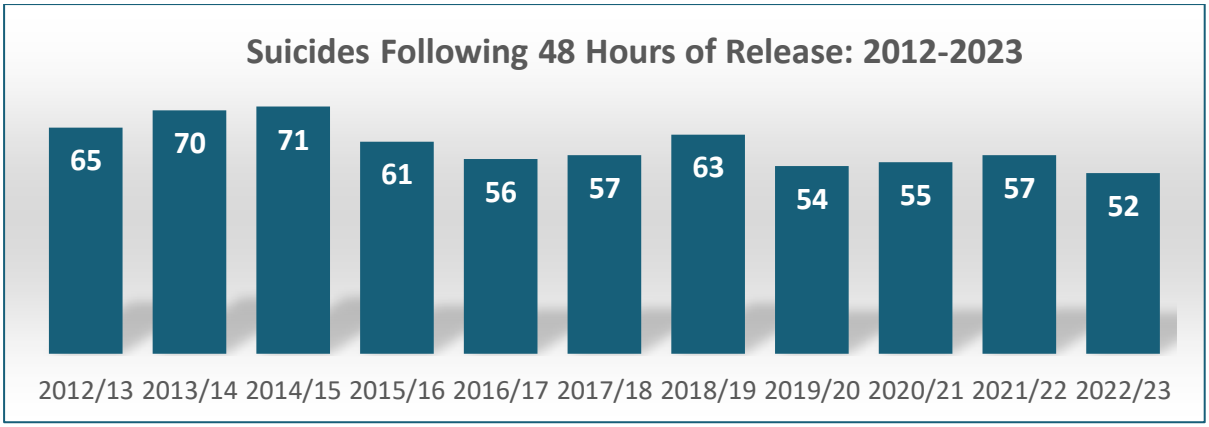
Background & Key Data

Over 2022/23, the IOPC reported **23 deaths in police custody, more than double the number of deaths compared to the previous year,** and the highest number of deaths since 2017/18.

Of the 23 individuals who died in custody, 11 experienced **use of force**, 13 had known **mental health** difficulties, and 21 had known links to **drugs and/or alcohol**. Ages of the deceased ranged from 20-93, whilst 22 individuals were male, and 1 was female. In terms of ethnicity, 19 were White, 2 people were Black, 1 person was Mixed-Race, and 1 person was Asian (for more details see IOPC: 'Deaths Following Police Contact', 2022/23).

The IOPC's 2022/2023 data, and several independent reports, including the Adebowale Report 2013, the Angiolini Review 2017, and the IAPDC's 'Preventing Deaths at the Point of Arrest, During and After Police Custody' 2022, (henceforth, the IAPDC Policing Report), **identify clear links between deaths in custody and mental health, substance misuse, and restraint**. IOPC data also reveals an **overrepresentation of Black ethnic groups** in comparison to the **general** Black population.

The IOPC's 2022/2023 data also revealed **52 apparent suicides within 48-hours of release from police custody**, which is likely to be much higher outside the 48-hour period. 24 deaths involved **alleged sexual offences against children** whilst 11 involved **suspected violence related offences** (non-sexual or murder).



The Ministerial Board for Deaths in Custody (MBDC) has committed to achieving a sustained reduction in the number of deaths across all custody areas in England and Wales. Given their statutory oversight and scrutiny responsibilities, PCCs have a key role to help realise this.

Guidance

Within this section, you will find optional guidance that is structured around PCC statutory responsibilities and evidence-based examples of what works.

Prioritising Safe Custody

As elected representatives, PCCs can send a clear message to the public by prioritising custody. This can include creating a specific priority commitment to a **'zero tolerance approach to deaths in custody'** which includes the safety of detainees, within their statutory Police and Crime Plans, and by providing community reassurance via their annual reports.

Case Studies: PCC Prioritisation

- **Merseyside's PCC** has set increased trust and confidence in the Criminal Justice system as a priority in the Police and Crime Plan (2021-25).
- **Greater Manchester's Mayor** has prioritised tackling deaths in custody as part of tackling drug-related deaths in the Police and Crime Plan (2021-25).
- **Kent's PCC** publishes local death in custody statistics within their annual report, following a recommendation made in the Angiolini Review.

Recommendation for Prioritisation

- ✓ **PCCs can** include a priority to hold their Chief Constable to account for the delivery of a safe custody environment within their Police and Crime Plan and provide updates on progress via annual reports.

Collaboration

The IAPDC Policing Report recommends forces work with local health providers and Voluntary Sector Organisations (VSOs) to explore options for support on release. PCCs can use their convening powers and electoral mandates to bring relevant partners together including forces, local authorities, and VSOs to agree on how best to collaborate and ensure appropriate support is available to vulnerable detainees following their release from custody.

PCCs, forces and wider partners may also wish to explore **options for delivering local VSO provisions within custody** given how custody provides an opportunity to support detainees, an approach that is reflected in the NPCC Custody Strategy (2022). On this basis, having VSOs based within custody can increase the likelihood a detainee will reach out for support in the community.

Case Study: Samaritans in Custody

The Samaritans and the City of London Police have a non-legally binding memorandum of understanding whereby the Samaritans provide **a free listening service** in custody suites to those who need it. As part of their role requirements, all Samaritans must undergo Disclosure and Barring Service background checks. The force provides Samaritans with training on custody procedures and have produced a terms of reference that explains the partnership.

The Samaritans visit custody suites 2-3 times a week in pairs. Once they arrive, a Custody Sergeant escorts them to detainees assessed as in need of support, but do not present a risk to the safety of the visitors. If the detainee agrees, the Samaritans will then engage with the detainee. To protect confidentiality, the Custody Sergeant must not be in ear-shot of the conversation, but within proximity to intervene if required for safety reasons.

If the detainee wishes to make use of their services, the conversation continues in the custody suite's interview room. For safety purposes, custody staff will

remain outside the interview room and CCTV can be switched on to monitor safety, but without audio. Samaritans can have the conversation with the detainee only if this does not delay evidential procedures. If the detainee wishes to speak to Samaritans upon release, this can be facilitated outside of the custody suite.

Bedfordshire Police have a local arrangement with Samaritans which is based on the City of London Police's model, whereby Samaritans visit specific custody suites.

In one case, a detainee disclosed thoughts of suicide to Samaritans which was not previously disclosed to the custody officer. Due to the risk posed to the detainee, custody officers were informed and enhanced safeguarding measures were put in place to prevent the risk of self-harm or suicide following their release from custody.

For more information see, Gwent's Police and PCC's work with local Samaritans and South Wales' local Samaritans in custody suites.

Case Study: Ex-Armed Forces and Charities

Further examples of how PCCs are working with charities have been identified by the IAPDC. In their Policing Report, the Panel highlighted the work of Project Nova, a charity that supports people with military experience who are in contact with the criminal justice system. Examples of PCCs delivering this type of activity include **Merseyside PCC**, where staff held a training session for ICVs on how to identify vulnerability and how detainees may be more likely to disclose vulnerabilities with ICVs. **Kent PCC** have also launched similar initiatives to offer detained ex-armed force veterans an opportunity to refer themselves to the Soldiers', Sailors' and Airmen's Families Association (SSAFA).

Case Study: Greater Manchester Collaborative Working

PCCs can also work with external partners to enhance their scrutiny mechanisms. This could be embedded into current scrutiny panels or existing boards dedicated to improving safety in custody.

For instance, **Greater Manchester Police's (GMP)** Organisational Learning Panel (OLP), is attended by GMP custody staff, the ICV Scheme Manager, ICV

lead visitor, and representation from the health care practitioner lead nurse. The Panel investigates recent adverse incidents within custody with a focus on how to improve future outcomes. Recommendations and actions from the OLP are reported to GMP's 'Custody Strategic Oversight Group', chaired by chief officers, which focuses on improving strategic custody activity.

GMP recently received a **positive** PEEL inspection report from His Majesty's Inspectorate of the Constabulary and Fire & Rescue Services (HMICFRS), which commented positively on their governance and performance arrangements.

Recommendations for Collaboration

- ✓ **PCCs can** bring force and third sector organisations together to discuss and arrange support for vulnerable detainees within custody and upon release.
- ✓ **PCCs can** invite external stakeholders to enhance scrutiny mechanisms with a focus on preventing deaths.

Holding to Account

PCCs have a variety of powers available to hold their Chief Constables to account for the prevention of deaths in custody. This section provides advice and recommendations on specific questions PCCs can ask their Chief Constables; suggestions for how ICVs can support oversight; and useful information on how PCCs can deliver Custody Detention Scrutiny Panels (CDSPs) - see Appendix B for an example of a scrutiny process map.

For more, see the APCC's PCC Accountability Framework guidance for further examples of PCCs holding their force to account across different areas of policing.

Scrutiny Questions PCCs Can Raise

PCCs can seek assurance and evidence of activity by raising the following questions with Chief Constables:

Question: What measures are in place to divert vulnerable people from custody?

What to look for: Because of the links between deaths in custody and mental health, PCCs should seek assurances on how their force divert vulnerable people away from custody to appropriate care and support. This may include

seeking evidence of implementing Right Care, Right Person, which aims to ensure vulnerable people get the right support from the right emergency services. PCCs should assess partnership input into plans to divert vulnerable people away from custody, such as evidence of effective referral pathways that can manage demand. See separate **APCC guidance** on Right Care, Right Person.

Question: Are there adequate risk assessment procedures in place to prevent deaths in custody and following release, i.e., managing mental health risk, substance misuse and suicide prevention?

What to look for: Whether custody satisfy HMICFRS expectations for custody risk management by applying appropriate level of observations, referring vulnerable people in custody to Liaison and Diversion (L&D) services or Health Care Practitioners, and ensuring suites are free from ligature points (see College of Policing Authorised Professional Practice {APP}: Detainee Care, and Building and Facilities). PCCs can also assess what measures are in place to ensure use of force at the point of arrest is proportionate to the situation, and only being used as a last resort as per College of Policing APP: Control, Restraint and Searches.

PCCs can also seek assurance that custody staff have received adequate training. For example, has the force delivered something comparable to **Nottinghamshire Police**, where the Learning and Development team provide an intensive four-week training programme to custody officers, which includes content around mental health pathways. This approach is highlighted as good practice by the IAPDC.

The IAPDC also recommended government departments, health partners, policing bodies, and PCCs to continue supporting comprehensive L&D and Street Triage coverage to ensure vulnerabilities are identified and managed in custody. PCCs may wish to encourage **24/7 L&D provision** to help deliver this recommendation.

Question: What support is provided to detainees at risk of suicide throughout the custody journey and at the point of release?

What to look for: Robust risk assessments conducted by forces throughout the custody journey which identifies early warning signs of suicidal behaviour. PCCs should ask Chief Constables what measures are in place to effectively capture key information from the moment of arrest and following transfer of detainees

to custody staff, ensuring warning indicators are not missed and relevant information properly informs pre-release risk assessments. For more information, see College of Policing APP: Custody Risk.

Has the force also considered embedding support services within custody? See examples relating to the **City of London Police** and **Bedfordshire Police** in the section above.

Question: In acknowledgement of how police officers are not best placed to safeguard detainees following release from custody, how is the force working with partners, including local authorities and VSOs, to connect detainees with appropriate support services in a timely manner?

What to look for: Northumbria Police has introduced healthcare practitioners and Liaison and Diversion teams embedded within custody all year round. These healthcare practitioners provide valuable support to vulnerable detainees, and outside of Liaison and Diversion hours, custody staff can refer individuals to the local NHS Foundation Trust.

In the absence of similar processes, PCCs could work with Chief Constables to bring partners together (i.e., local authorities and VSOs) or attend relevant health forums, such as Health and Wellbeing Boards or Welsh equivalents, to develop pathways to support vulnerable detainees at risk of suicide following release from custody. PCCs could also make use of the partnership model utilised for local RCRP delivery, raising preventing deaths in custody and apparent suicides following release as an item of discussion with partners.

Question: What support is being provided to the bereaved family and is their experience being considered to prevent future deaths?

What to look for: The tragic experience of a death in police custody or a suicide following release from custody will be traumatic for the bereaved family. Bereaved families often seek assurances that a similar experience will not occur, and that valuable learning is embedded in force policy. INQUEST, a charity supporting bereaved families, and the IAPDC, advocate for families, subject to their agreement, to have a role in the investigation process as a source of learning and recommend forces seek out and incorporate their views in their learning activities.

PCCs can seek reassurance from Chief Constables by asking what policies are in place to support bereaved families. For instance, do they provide post-death leaflets and do they ensure the families' input supports the investigation process? For more information see, INQUEST's Family Listening Days sessions.

Question: Does your force have a policy in place to review and embed learning following a death in custody and near misses?

What to look for: The IAPDC recommend PCCs, the NPCC, and the College of Policing share learning following a death in custody, suicides after release, and near misses to standardise preventative mechanisms across forces.

PCCs should flag concerns raised from Prevention of Future Death reports, published by the Chief Coroner, and IOPC recommendations directly with their Chief Constables to assess whether the force has amended internal policies in response. PFDs are highlighted in the IAPDC's report, 'More than a paper exercise', which recommends all agencies involved with scrutinising detention should make use of PFDs. **Note: ICVA also circulate PFD reports to all member OPCCs**.

Independent Custody Visitors

ICVs provide an important mechanism for PCCs to ensure safeguards are in place to prevent deaths in custody and following release by raising concerns with the force when they suspect a detainee is at risk of death or suicide.

PCCs may wish to ensure their ICV schemes can access relevant training and understand that if they suspect a detainee is at risk of death, self-harm, or suicide, they can raise this with custody officers to ensure the appropriate measures are in place by either asking the custody officer or checking custody records (upon the detainee's consent) that:

- ✓ **Transport has been arranged,** such as providing access to public transport, i.e., a free bus / train ticket. Learning identified in a PFD Report shows the risk of releasing a vulnerable person from custody with no arranged transport.

- ✓ **The detainee has the means to contact family members** in order to get home safely. If this is not possible, ICVs may seek assurance that, subject to the detainee's permission, efforts are made to contact family members. These approaches may have greater significance when detainees are

released at times of the day when public transport is not readily available or during adverse weather.

- ✓ **Appropriate referrals to health, social care or VSOs have been made**. This includes Liaison and Diversion services who can refer vulnerable individuals to appropriate health or social services in the community, custody Health Care Practitioners, or VSOs such as the Samaritans or Project Nova.

- ✓ **Vulnerable detainees are placed under enhanced observation levels** to prevent harm in custody, in line with College of Policing APP: Detainee Care. For further information, see free ICVA training material here.

- ✓ **Custody suites are adequately resourced.** The IAPDC's report into suicide across custody settings notes that increased workloads can cause officers across custody settings to become desensitised to self-harm or suicide. ICVs should monitor and enquire with custody staff whether they have appropriate resources to perform their duties - are there enough staff and do they have access to support.

- ✓ **Adequate equipment is administered to vulnerable people in custody.** For instance, PCCs may be interested in practice from **Devon and Cornwall Police** where they have introduced detainee heart monitors that alert custody officers if heart rates drop- ICVs reported positively on these. **In Hampshire and Isle of Wright**, ICVs check custody staff are carrying ligature knives to prevent self-harm and are using them in line with College APP: Building and Facilities.

Ensuring your ICV scheme has access to relevant training and resources will support their ability to effectively play a role in preventing deaths in or following custody. Examples of how PCCs can support ICVs with resources and training includes:

- ✓ **Sharing up to date material with ICVs**, such as:
  - **IOPC's 'Learning the Lessons'** on police custody and mental health,
  - **IOPC investigation outcomes** (see here for an example), and
  - **PFD reports,** which review the circumstances which led to a death in or after police custody alongside recommendations. PFDs can be accessed by clicking here. **Note: they are also shared by ICVA to its members**.

- ✓ **Highlighting deaths in and following custody during PCC-led meetings (including incidents from other force areas).** This may include providing ICVs with opportunities to review deaths and near-misses, and steps taken around prevention.

Case Study: Process Following a Death in Custody

The following approach should be considered by the PCC and staff for when a death occurs in their area:

- Ensure there are arrangements in place for the force to inform PCCs and their offices when a death in custody occurs.
- When practicable, an ICV visit should then be arranged to the custody suite where the incident occurred.
- The PCC's office should then discuss the incident directly with senior officers (for instance, the force's custody lead) during a PCC-led panel meeting.

Note: As per Article 2 of the European Convention on Human Rights (ECHR), all deaths that occur in police custody and following police contact must be referred to the relevant independent investigative authority for investigation, therefore, PCCs and OPCCs should be mindful that an IOPC investigation will be in progress and may want to await the outcome of this process prior to taking action. For more info see, College of Policing APP: Deaths in Custody.

Custody Detention Scrutiny Panels (CDSPs)

The APCC and NPCC have developed joint guidance to support forces and PCCs to establish CDSPs, which include members of the local community, and provide valuable opportunity to scrutinise police custody, including issues relating to the safety and welfare of detainees.

CDSPs can scrutinise areas of custody to ensure the force have appropriate measures in place to prevent deaths. This includes **reviewing adverse incidents** (this includes a death, or near-miss), scrutinising **pre-release risk assessments**, ensuring they follow College APP: Detention and Custody Risk Assessment and HMICFRS custody expectations on pre-release, and **use of force incidents** to ensure rationales behind the decision were clear and justified.

Focusing on scrutinising use of force in custody and safeguarding protocols for vulnerable detainees can also help identify potential disproportionality on the grounds of race, issues which were highlighted in the Angiolini and Baroness Casey reviews.

Case Study: Bedfordshire's CDSP

Bedfordshire's PCC first launched a pilot CDSP in November 2023, with subsequent panels taking place every quarter hereafter. As of February 2024, the panel consists of seven ICVs, four members of the community, and a chair, with consideration being given to recruiting panellists with lived experience. Whilst members are not required to be vetted, they are required to sign a non-disclosure agreement.

The force provides panel members with quarterly data including use of force (as well as use of anti-rip clothing), Liaison and Diversion services, mental health (use of section 136 of the Mental Health Act {1983}), and the work of Samaritans based in custody. This is provided at the start of the meeting to avoid data breaches.

Panel findings are shared with the force for response with the aim of improving practice or identifying training needs. For more information, see Bedfordshire's CDSP's webpage.[1]

Recommendations for Holding to Account

PCCs can:

- ✓ Consider scrutinising deaths outside of the custody suite relating to point of arrest and transportation.
- ✓ Ask what level of support is provided by forces, health/ social partners, and Voluntary Sector Organisations throughout the custody journey and at the point of release.
- ✓ Assess what steps are being taken to address concerns raised by Prevention of Future Death reports and recommendations issued by the Independent Office for Police Conduct.

ICVs can:

- ✓ Enquire with the custody officer or review custody records to assess whether adequate safeguarding measures are in place.

[1] If you would like a copy of Bedfordshire's CDSP terms of reference, please contact PCC@beds.police.uk.

OPCCs can:

- ✓ Create a process for handling a death in custody which could be included in internal OPCC policy documents.
- ✓ Include deaths in custody as a thematic focus for CDSPs by scrutinising adverse incidents, pre-release risk assessments and use of force.

Appendices

Appendix A: Additional Resources

Key Stakeholders:

- Independent Advisory Panel for Deaths in Custody
- Ministerial Board for Deaths in Custody
- Home Office
- Independent Custody Visiting Association
- National Police Chiefs Council
- His Majesty's Inspectorate of the Constabulary and Fire & Rescue Services
- Independent Office for Police Conduct

Key Reports:

- Independent Advisory Panel for Deaths in Custody, **Preventing deaths at the point of arrest, during and after police custody (2022)**
- Independent Office for Police Conduct, Deaths Following Police Contact (2022/23)
- Dame Elish Angiolini, Report of the Independent Review of Deaths and Serious Incidents in Police Custody (2017)

Charities:

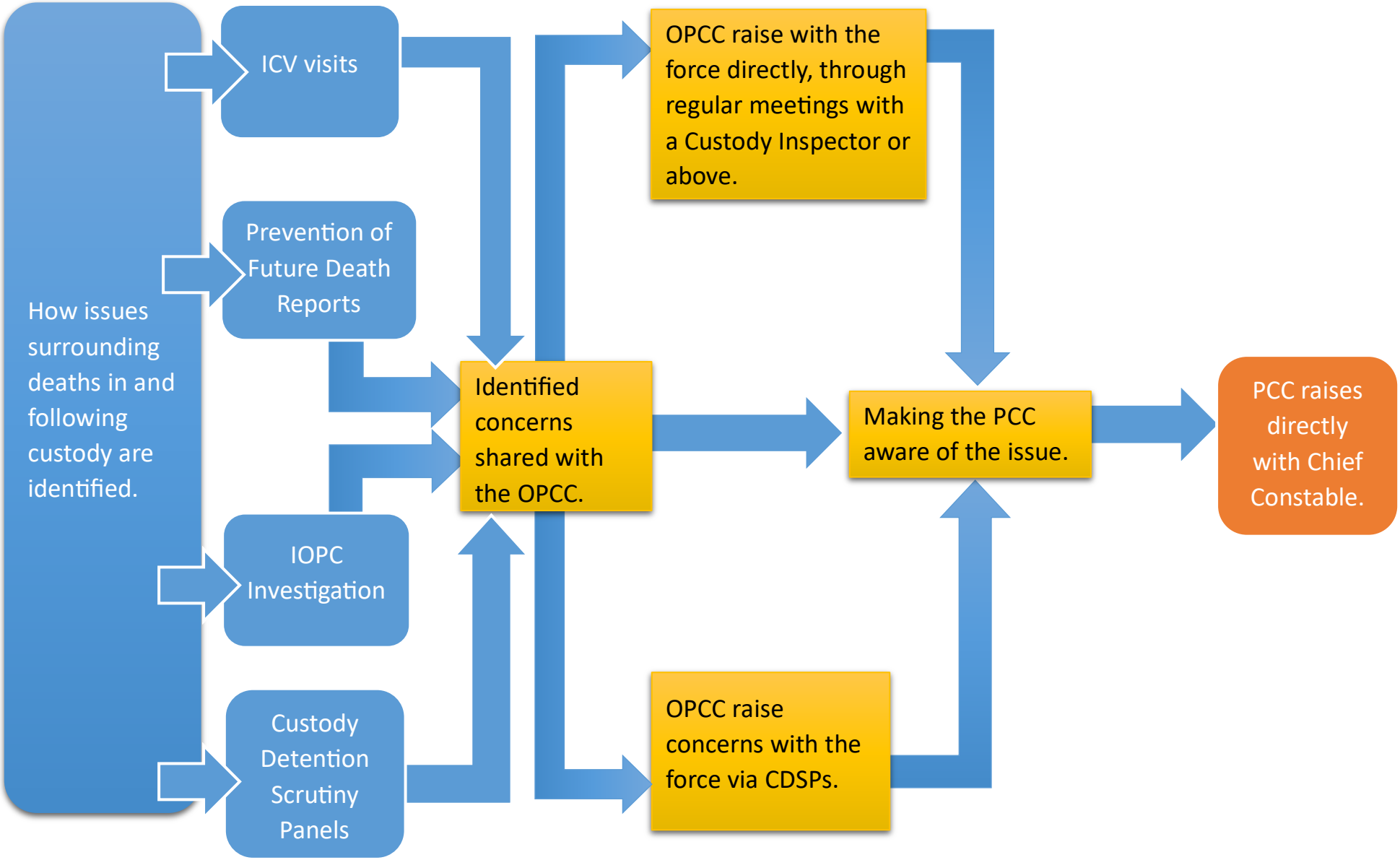
- 'Stop if now' helpline is available for adults who are concerned about their own thoughts and behaviours.
- Project Nova & The Soldiers', Sailors' and Airmen's Families Association- charity services which support ex-armed force veterans who have come into contact with the criminal justice system.
- Samaritans- is a free listening service to provide emotional support for people who are struggling to cope.
- Circles of Support- support convicted sexual offenders to prevent suicide and reoffending.

- Inquest- support bereaved families following a death where state accountability is involved, such as a death in custody.

Further Resources:

- College of Policing: Detention & Custody Authorised Professional Practice
- Independent Advisory Panel for Deaths in Custody: Statistical Analysis of Recorded Deaths in Custody Between 2017 and 2021
- Government Suicide Strategy (2023-28)
- Welsh Suicide Prevention Strategy (2015-22)- the Welsh government are drafting a new strategy for 2024-34.
- Rebecca Key, et al, Suicidal behaviour in individuals accused or convicted of child sex abuse or indecent image offences.
- Duleeka Knipe, et al, Suicide rates in high-risk high-harm perpetrators of domestic abuse in England and Wales

Appendix B: Holding to Account Process Map



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The APCC provides support to Police and Crime Commissioners and policing governance bodies in England and Wales.

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