Association of Police and Crime Commissioners

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

Last Update: April 2025

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 suicides following release.

Table of Contents

Foreword

Kate Green, APCC Mental Health & Custody joint lead and Greater Manchester's Deputy Mayor for Safer and Stronger Communities

I am pleased to see PCCs across England and Wales engage with the recommendations previously set out when this guidance launched in June 2024, with many areas exploring partnerships with local charities, delivering effective scrutiny, and increasing awareness locally. I am also pleased to see key partners promote this guidance nationally, such as the College of Policing, and the Independent Advisory Panel for Deaths in Custody (IAPDC). However, it is important that we maintain momentum on this important issue. That is why I have renewed and updated this guidance with up to date resources and new case studies.

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) and Deputy Mayors can play a key role in encouraging policing to strive for the highest standards possible by delivering effective scrutiny and oversight of policing, be

it through our meetings with Chief Constables, independent scrutiny panels, 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) (October 2024), 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 a system of precautions, procedures, and training that will to the greatest extent protect life, including following release from police custody.

More can be done to identify and reduce risk, and to help vulnerable people access vital support upon release from custody. 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.

This guidance has been developed with incredibly helpful input from PCC colleagues across England and Wales, and the expertise of national partners including the IAPDC and the National Police Chiefs' Council (NPCC). I would like to thank all those who have kindly contributed to what I hope you will find 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 and updated by the APCC to support the prevention of deaths in police custody and 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.

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.

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 risks associated with deaths in police custody and suicides following release.**

- **Support PCCs to scrutinise police custody arrangements to help prevent deaths and suicides.**

- **Support 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.**

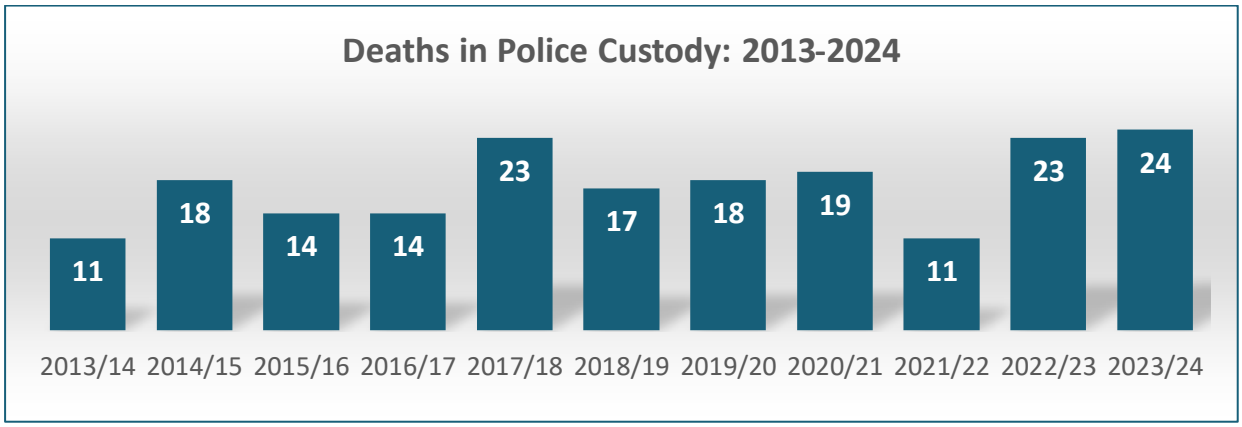
The APCC encourages feedback on all its resources. If you would like to share feedback on how this guidance has supported you in delivering your responsibilities, or have examples you would like to be considered in updated versions of the guide, please contact the APCC (see contact us section).

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 guidance is member-led and features evidence-based case studies.

Background and Key Data

Over 2023/24, the IOPC reported **24 deaths in police custody, the highest figure since 2006/07.**



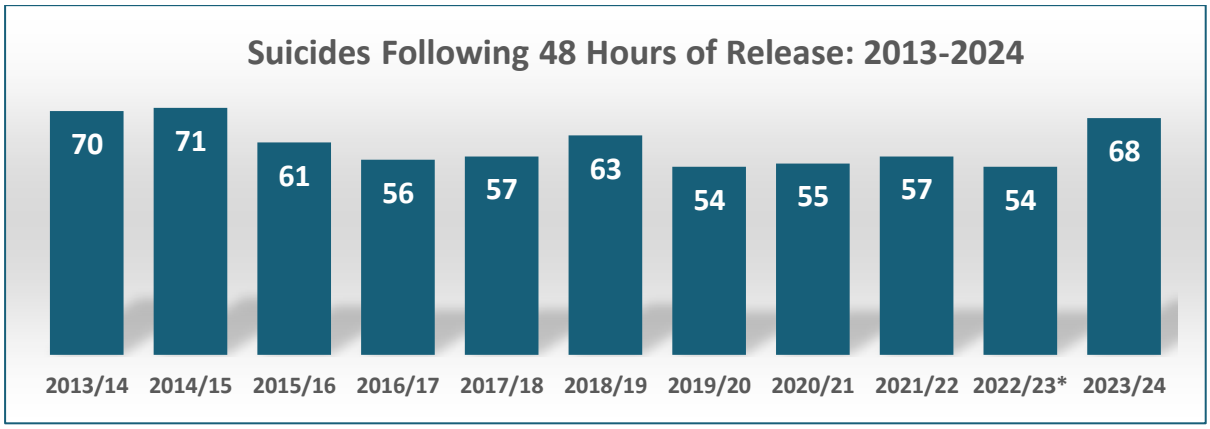
Of the 24 individuals who died in custody, 15 people became ill or were identified as ill **in a police cell**, 11 were taken to a hospital where they later died, 4 people died in the police cell, and 1 person died by suicide (the last incident of this kind took place during 2016/17).

21 people had known links to alcohol or drugs, 19 had mental health concerns, and 14 had some use of force used against them by officers or members of the public.

The IOPC's 2023/2024 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**.

The IOPC's 2023/2024 data also revealed **68 apparent suicides within 48-hours of release from police custody**, which is likely to be much higher outside the 48-hour period.[1] 26 deaths involved alleged sexual offences against children, whilst 15 involved suspected violence related offences (non-sexual or murder).



* The IOPC reported 52 post custody suicides at the time of the APCC's guidance release in June 2024.

For further information, click here to review the IOPC's most recent data for deaths and suicides in and after custody.

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

[1] The IOPC define suicides as 'apparent' because the association may not be clear. As a result, there may be more suicides then reported here by the IOPC.

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

It is essential that the use of intrusive powers is closely scrutinised. PCCs preform an important role as local community leaders, and have the opportunity to send a clear message to the public by making the prioritisation of custody a central focus. By doing so, this can demonstrate a strong commitment to the public ensuring safety and wellbeing of those who are detained in custody. This can include creating a specific commitment to the safety of detainees within their statutory Police and Crime Plans, and reinforced through annual reports.

For example, **Greater Manchester's Mayor** has set increased public trust and confidence in the Criminal Justice system as a priority in the Standing Together Plan (2024-29), and **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 secure support for detainees upon 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 people following their release from custody.

Notable collaborative practices to look out for include **Northumbria Police**, who have introduced Health Care Practitioners (HCPs) and Liaison and

Diversion (L&D) teams embedded within custody all year round. These healthcare practitioners provide valuable support to vulnerable detainees, and outside of L&D hours, custody staff can refer individuals to the local NHS Foundation Trust. In addition, **Surrey Police** are currently working with L&D and Mountain Healthcare to develop enhanced out of hours support referral mechanisms outside of L&D core operating hours. This provides more people leaving custody with the opportunity to address offending behaviours through wider support services available within the community setting.

Whilst good practices exist, the IAPDC have highlighted the variance in the way Liaison and Diversion (L&D) schemes operate and their availability. The IAPDC recommend stronger multiagency collaboration to ensure referral support is not a postcode lottery, and all vulnerable detainees leaving custody are provided with the appropriate support. 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 Right Care, Right Person (RCRP) delivery, which aims to ensure vulnerable people get the right support from the right emergency services, for raising preventing deaths in custody and suicides following release as an item of discussion with partners. For examples of PCC mental health governance arrangements, please see the APCC's guidance for RCRP, and for further recommendations on enhancing PCC partnerships, please see the APCC's Findings On Toward Better Local Partnership Systems In England And Wales.

In additon to local mental health providers, PCCs, forces, and wider partners may also wish to explore **options for delivering local VSO provisions within custody,** such as the **Samaritans** as they can increase the likelihood a detainee will reach out for support in the community. Samaritan provision has been recommended to support detainees at risk of harm in the Dame Vera Baird Inquiry (2024). It also supports the NPCC Custody Strategy (2022), and the commitment from government, to create a safe area to assess and support vulnerabilities.

Case Studies for Collaboration

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 (DBS) background checks. The force provides the 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. Samaritan volunteers have been shown how to summon urgent help, custody staff do not allow Samaritans to be in a dangerous situation, and they dynamically risk assess any unsupervised conversation. 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 other examples see, Gwent's Police and PCC's work with local Samaritans and South Wales' local Samaritans in custody suites.

Case Study: Ex-Armed Forces Charities

Further examples of how PCCs are working with charities have been identified by the IAPDC. In their Policing Report, the IAPDC 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 as members of the public. **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).

Recommendations for Collaboration

- ✓ **PCCs can** bring force, mental health partners, and VSOs 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.[2] This may include seeking evidence of implementing RCRP. 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 RCRP.

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 (2022) [3] by applying appropriate level of observations, referring vulnerable people in custody to L&D services or HCPs, 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.

PCCs may also wish to check if custody suites are checked for ligature points every two months, which is currently practiced by **Surrey Police**. Surrey's last custody HMICFRS inspection in 2021 found no ligature points in custody, which is believed to have been a national first.

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

[2] The Mental Health Bill 2025, currently going through parliament, will seek an end to the use of custody as a place of safety.
[3] HMICFRS custody inspections will likely move into the PEEL inspection framework meaning aspects of custody expectations are likely to change.

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, is conducted in the presence of the detainee, and is clearly documented. 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: Detention and Risk Assessment and HMICFRS Custody Expectations (section 5).

Has the force also considered embedding support services within custody? See examples on collaboration in the previous chapter.

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 (PFD) 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.

Case Studies for PCCs Holding to Account

Case Study: South Wales PCC Scrutiny & Accountability Board

The PCC for South Wales runs a Scrutiny & Accountability Board which closely scrutinises specific policing issues which are set out in the Police and Crime Plan. The Board recently undertook a Deep Dive into South Wales Police custody's response to the 2023 HMICFRS Inspection. Attendees of the Board included the PCC's Chief Executive, senior custody leadership, and South Wales Police's Deputy Chief Constable.

Following the Board, the PCC's office made several recommendations to South Wales Police including training staff on trauma informed practices, mental health, and neurodiversity to reflect the demand issues within custody. The PCC's office will continue to oversee custody's progress against the recommendations.

Case Study: Leicestershire's Ethics Panel

Leicestershire PCC's Ethics and Transparency Panel members held the force to account at their quarterly meeting. The panel members, which included the Deputy PCC, reviewed Leicestershire Custody Procedures and analysed the ICV Scheme Quarterly Report.

The force provided reassurance that a policy change was implemented to ensure individuals in custody were checked to confirm they were awake during

cell visits, and that officers must document these checks within the custody record. For a copy of the panel's minutes, click here.

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 been offered 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 HCPs, or VSOs such as the Samaritans or Project Nova. Following their HMICFRS inspection, **Hampshire and Isle of Wright ICVs** check Pre-Release Risk Assessments where appropriate to ensure they provide necessary safeguards to prevent self-harm prior to a detainee's release. In addition, **South Wales OPCC** and ICV Scheme Manager recently established a risk assessment dip sample pilot, analysing six custody records which involved child sexual offences. South Wales OPCC developed a checklist based on College of Policing APP for Risk Assessment and HMICFRS Custody Expectations (section 5) related to risk assessments throughout the custody

process, including pre-release, and used it to evaluate South Wales Police compliance. Findings from the Pilot are now being considered by the OPCC to feedback to South Wales Police.

- ✓ **Vulnerable detainees are placed under enhanced observation levels** to prevent harm in custody, in line with College of Policing APP: Detainee Care. **South Wales and Hampshire and Isle of Wight ICVs** prioritise vulnerable detainees during their visits to ensure the appropriate safeguards are in place.

- ✓ **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. 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 of Policing 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.**
  - **PFD reports,** which review the circumstances which led to a death in or after police custody alongside recommendations. **Note: they are also shared by ICVA to its members**.
  - Sharing training material such as the ICVA's suicide awareness bitesize training.

- ✓ **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.

- ✓ **Hold a training session on suicide awareness.** For example, **Surrey Police** recently held suicide prevention awareness training for the ICV scheme. It covered suicide risk factors, prevention techniques, and signposting for help. Following the session, **Surrey OPCC** discussed the topic in-person with ICVs and explored with Custody Inspectors what would happen to a detainee who is suicidal. For more information, click here to view the training session.

Process Following a Death in Custody

The following approach should be considered by the PCC and OPCC if 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 or a post-custody suicide 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 and Crown Prosecution Service legal guidance.

Case Study: Leicestershire OPCC Process Following a Death

Leicestershire ICV scheme held the force to account at their quarterly meeting following a death in custody and sought lessons learnt to prevent deaths in police custody.

The force responded to confirm that they put in place a Post Incident Management process, which is a special process that ensures that the force

capture all the witnesses and evidence to support the IOPC in their independent investigation.

Scrutiny Panels

The APCC and NPCC have developed joint guidance to support forces and PCCs to establish Custody Detention Scrutiny Panels (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, justified, and clearly documented.

Focusing on scrutinising use of force in custody and safeguarding protocols for vulnerable detainees can also help identify potential mistreatment in the custody environment. For instance, disproportionality on the grounds of issues relating to protected characteristics, which were highlighted in the Angiolini and Baroness Casey reviews; unlawful arrests and inappropriate strip searches, especially when women are stripped searched, which can be particularly traumatising and lead to a mistrust of police services, issues identified in the Dame Vera Baird Inquiry.

Case Studies for Scrutiny Panels

Case Study: Greater Manchester Scrutiny Panel

Greater Manchester Police (GMP) have developed an Organizational Learning Panel (OLP) 18 months ago by the Chief Inspector. It has been instrumental in promoting collaboration with partners when reviewing adverse incidents.

Considering the HMICFRS inspection and Dame Vera Baird's recommendations, GMP aim to become national exemplars in custody. GMP undertook a comprehensive deep dive into both the OLP and the adverse incident process, given their interdependency. This review necessitated a pause on further OLP meetings to allow time for reflection and has led to significant enhancements

in how GMP manage adverse incidents, ensuring timely and effective responses. This deep dive has culminated in a fully refreshed adverse incident process launching on 12th December. It was necessary to revisit and refresh the OLP to align with these changes.

As part of this refresh, GMP have strengthened collaboration with the Tactical Organizational Board and the Professional Standards Branch, ensuring a more integrated approach. A refreshed OLP, launching soon, will feature terms of reference that build on the learning from the original panel, while also incorporating GMP's improved processes and expanded partnerships.

Case Study: Bedfordshire's CDSP

Bedfordshire's PCC first launched a pilot CDSP in November 2023. Initially meetings were quarterly which has now moved to bi-monthly. As of January 2025, the panel consists of 6 ICVs, 8 members of the community, a chair and vice chair, with consideration being given to recruiting lived experience panellists. Members are not required to be vetted, but are required to sign a non-disclosure agreement, and all meetings are in person.

The force provides panel members with bi-monthly data and access to full custody records, including use of force, use of anti-rip clothing, L&D services, mental health (use of section 136), 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.

Case Study: Dyfed-Powys Scrutiny Panels

Dyfed-Powys Police run a Near-Miss and Adverse incident panel held monthly. The panel reviews an event in custody that results in injury or ill-health; near-misses or undesired circumstances; or where an event or dangerous set of conditions have occurred but have not resulted in an injury. Any learning helps inform ICVs and future scrutiny activities.

Dyfed-Powys OPCC run an Custody Independent Scrutiny Panel (CISP) which considers topics related to deaths in custody and suicides, such as anti-harm

suites, vulnerable detainees, as well as other topics including women and girls and children in custody. The panel is made up of ICVs and other members of the PCC's volunteer schemes who were provided training by the force to cover the procedures on detainee safety. Recently, the panel dip sampled 16 custody records, reviewing observation levels, HCP provision, and use of force. The panel identified only a small number of issues related to the use of force and mental health provision, a detailed force response can be found by clicking here, pages 7-13.

Case Study: Surrey's CDSP

Surrey Police introduced a CDSP in 2021 which is chaired by a member of the OPCC. All full panel is held once every six months and includes ICVs, the ICV scheme manager, and regular attendance by the Deputy Chief Constable and the Deputy PCC. In between the panels, a sub-group meets in person to scrutinise specific custody practices.

Standing agenda items for the full panel meetings include a specific thematic such as disproportionality, local custody trends, national custody publications, and ICV visit outcomes. The sub-group sample randomly selected custody records and review CCTV footage for use of force and strip searches to ensure actions in custody were proportionate, lawful, and necessary. These dip checks supplement wider compliance checks on custody records to ensure they are recorded appropriately.

Deaths in custody features regularly on the agenda where Surrey Police have provided updates against various national reports, including the previous iteration of this APCC guidance document. The force was able to provide reassurances of local safeguarding mechanisms, such as the force being free from ligature points, as highlighted in the previous section.

Case Study: South Wales' Scrutiny Panels

The South Wales ICV Scheme Manager participates in the '**Custody Lessons Learnt' forum** which is also attended by senior South Wales Police custody leadership, Health & Safety, and Learning and Development teams.

The purpose of the forum is to scrutinise recent adverse incidents and reflect on any learning or action taken as a result. The ICV Scheme Manager updates the ICVs following the forum meetings.

Recent learning and discussions from the meetings relate to the recording of adverse incidents/health and safety issues and training provided to custody staff regarding the use of the new metal detectors in custody, which are now in place across the four custody suites.

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 and social care 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 issued by coroners 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.

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 scrutiny panels by scrutinising adverse incidents, pre-release risk assessments, and use of force.

Appendices

Appendix A: Additional Resources

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 (2023/24)
- **Dame Elish Angiolini,** Report of the Independent Review of Deaths and Serious Incidents in Police Custody (2017)
- **Dame Vera Baird,** 'The Baird Inquiry: An independent report into the experience of people who are arrested and taken into custody by Greater Manchester Police with a focus on women and girls' (2024)

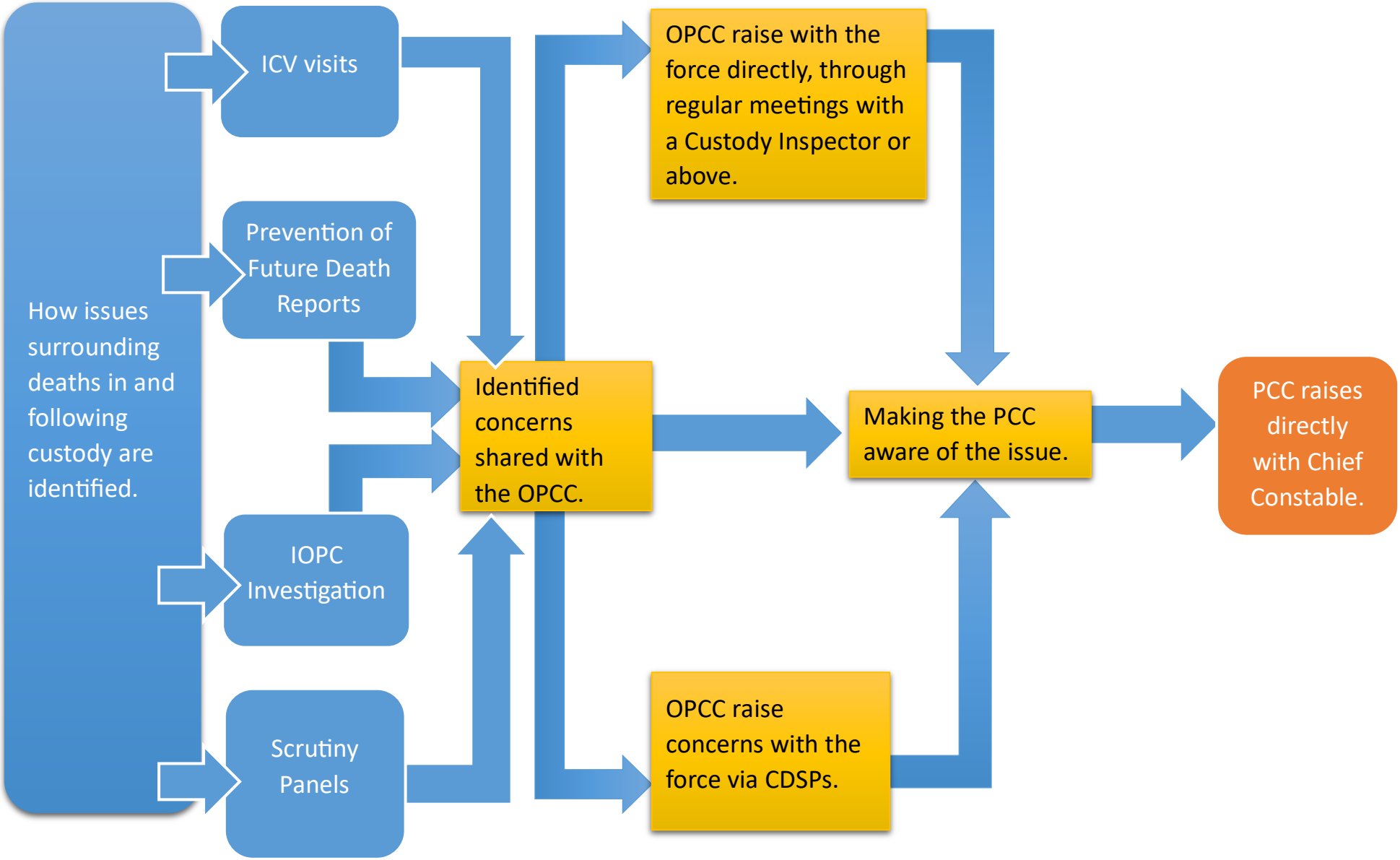
Charities:

- 'Stop if now' helpline is available for adults who are concerned about their own thoughts and behaviours.
- Project Nova and 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): Note the Welsh government are drafting a new strategy for 2024-34.
- Crown Prosecution Service: deaths in custody legal guidance

Appendix B: Holding to Account Process Map



CONTACT US

Association of Police and Crime Commissioners:
Lower Ground, 5-8 The Sanctuary, Westminster, London SW1P 3JS

Telephone: 020 7222 4296
Email: enquiries@apccs.police.uk
Website: www.apccs.police.uk

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

Association of Police and Crime Commissioners