(POP0071)

Written evidence from Independent Advisory Panel on Deaths in Custody (POP0071)

The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials on how they can meet their human rights obligations to take active steps to prevent deaths in custody. The IAPDC welcomes the opportunity to submit evidence to the Home Affairs Select Committee inquiry into policing priorities. For our response, we have provided answers relevant to our single purpose of preventing all deaths, both natural and self-inflicted, in custody:

- **In a modern police service fit for the 2020's, it is vital that police continue to discharge their fundamental duty to protect the lives of the public, including meeting the specific obligation to safeguard the lives of people held in their custody**. Every death in police custody is a tragedy and such deaths are largely preventable. Forces know all too well the devastating impact deaths related to police contact or custody can have on trust and relationships with the communities they serve, particularly those of BAME backgrounds.

- The number of deaths during and following police custody has remained at similar levels for the last decade, while deaths within custody suites have fallen in part due to improved observance of codes of practice. However, a high proportion of deaths involve people who are experiencing mental health and and/or substance misuse crises, and each year there remains a large, and largely neglected, number of self-inflicted deaths that occur soon after release from custody.

- This evidence draws from the IAPDC's work with Police and Crime Commissioners (PCCs) and policing bodies to identify ongoing action by police aimed at preventing these deaths from happening and ensuring forces learn from them when they do. The IAPDC presents these measures not as fully evaluated examples of 'best practice', but as a range of actions highlighted by police themselves that need stronger focus, evaluation, and sharing among forces. As leaders look to refocus police priorities, we hope to identify what can help forces prevent deaths in custody as an integral part of the core business of policing.

- Our evidence draws together examples of ways to keep people safe submitted by 27 forces, via their PCCs, and three police representative bodies across England and Wales. Police forces themselves profiled these practices as central to their efforts to prevent deaths, particularly the partnerships they have built with allied health and justice services to play to professional strengths and considerably reduce inappropriate use of police time. Our evidence also identifies significant gaps in practice relating to our identified priority areas, as well as extensive opportunities to better embed and share learning after deaths in custody.

- Mental health: 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. Different cross-agency schemes, such as street triage, L&D support, and clinically-led places of safety, 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. Fundamentally, many of the difficulties forces face in this area relate to the availability of mental healthcare provision, and we urge both police forces and healthcare partners to ensure it is mental health teams, and not police, who are first-responders to those in crisis.

- Apparent post-custody suicides: All but two of the responses we received from PCCs highlighted assessments which are carried out pre-release to screen for risk of future self-harm or suicide as part of efforts to stop the large number of self-inflicted deaths following custody. This can range from multi-agency approaches to mental health and general wellbeing, to efforts to signpost individuals to support through leaflets and posters in custody suites. However, despite recognition of the need to assess individuals prior to release, there does not appear to be significant evidence of after-care or follow-up work done. We urge forces to build on this work to prevent these avoidable deaths.

- Embedding learning: Some forces appear to have the culture, leadership and structures in place to learn lessons and keep the prevention of deaths in custody at the forefront of the minds of staff. However, very few responses referred to how learning was shared between forces or described the liaison with, and learning from, bereaved families, and none referenced the role disproportionality and race may play in this area. We believe that forces and policing bodies should do more to share learning across the 43 policing areas in England and Wales.

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Introduction

1. The number of deaths during and following police custody has remained at similar levels for the last decade, while deaths within custody suites themselves 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.[1] In 2021/22, three people died in a police cell, a continuation of a long-term reduction since the 1990s from earlier years.[2]

2. Every death in police custody is a tragedy and such deaths are largely preventable. The findings from inquests into the deaths of Kevin Clarke and Kelly Hartigan Burns, among others, have provided a stark reminder of matters of concern which have yet to be rectified.[3] 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 Prevention of Future Deaths reports from coroners.

3. As Government and police forces seek to focus on getting the basics of policing right, it is vital that police continue to discharge their fundamental duty to protect the lives of the public, including those in their custody. Forces know all too well the devastating impact deaths connected to police custody can have on relationships with the communities they serve, particularly those of BAME backgrounds. Preventing such deaths is vital to getting the basics of policing right.

4. 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, six of the 11 people who died were identified as having mental health conditions and nine people were known to have links to alcohol and/or drugs.[4] Both factors are also prevalent among the 109 people who died in 2021/22 after some form of contact with the police, some of whose deaths occurred in circumstances that raise questions about the police's involvement.[5] The focus now must be on preventing all deaths at point of arrest, in police custody, and following contact, and identifying ways to ensure that the lives of most vulnerable, such as those in mental health crisis, are not put at risk.

5. Following discussion at the Ministerial Board on Deaths in Custody, in 2021 the IAPDC embarked on an information-gathering exercise 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. In 2021, the then-Policing Minister, the Rt Hon Kit Malthouse MP, and Juliet Lyon CBE, Chair of the IAPDC, sent two joint letters to all Police and Crime Commissioners (PCCs) in England and Wales, asking for good local practice examples on how forces work to prevent, or respond to, and learn from deaths.[6]

6. Between March and April 2021, and then November 2021 and January 2022, we were grateful to receive a total of 27 responses from a possible 43 force areas, in addition to three associated organisations and representative bodies. Responses were taken in good faith and not verified with the senders, while further progress is also likely to have occurred since submissions were made. During the research period, the panel discussed interim findings and updates with the then-Policing and Health Ministers, along with meetings with key stakeholders, such as the families bereaved by deaths in custody and senior leaders within the College of Policing.

7. The IAPDC recognises the range of existing expert reports and resources which set out recommendations and good practice to prevent deaths. These include *Six Missed Chances*,[7] 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;[8] and Dame Elish Angiolini's landmark *Report of the independent review of deaths and serious incidents in police custody*.[9]

8. In this submission, the IAPDC has summarised the evidence it received and drawn out key themes and learning which bear significantly on the questions asked by the Committee in its inquiry. Importantly, this project has not involved evaluation of these activities by police for their effectiveness in preventing deaths in custody. Rather, it is intended to catalogue the myriad ways in which police forces are seeking to do so, identifying areas which may need stronger focus, rigorous evaluation, and then sharing among forces across the country. A full, separate report analysing this evidence will shortly be published by the IAPDC, who will then work with new Ministers and policing partners to disseminate and address its findings.

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Summary of responses from Police and Crime Commissioners and Chief Constables

Mental health and risk

9. **Summary:** 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. 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. Fundamentally, many of the challenges forces face in this area relate to the availability of mental healthcare provision, and police forces and healthcare partners must work together to ensure it is mental health teams, and not police, who are first-responders to those in crisis.

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

11. 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. 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.[10]

    b. The use of liaison and diversion (L&D) teams was 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 found that all forces had commissioned services which included an L&D service within police custody.[11]

12. PCCs were 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), 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.

13. PCCs highlighted a number of apparent successes in this area. For example, as a result of strong partnerships with health and social care, Hampshire has witnessed 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.

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14. 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.[12] 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.

15. 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.

16. 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 factors to ensure there is strategic oversight and treatment pathways are considered.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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. Some forces have 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.

22. 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.

Apparent post-custody suicides

23. **Summary**: All but two of the responses we received highlighted assessments which are carried out pre-release to screen for risk of future self-harm as part of efforts to stop the large number of self-inflicted deaths following custody. This can include multi-agency approaches to mental health and general wellbeing, and efforts to signpost individuals to support through leaflets and posters in custody suites. However, despite recognition of the need to assess individuals prior to release, there does not appear to be significant evidence of after-care or follow-up work done. Our evidence includes recommendations to build on this work to target what remains an all-too large number of deaths.

24. 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.[13]

25. 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 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.

26. 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.[14]

27. Specific examples of potential good 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"*.[15]

    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.

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

28. 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. 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.

Embedding learning

29. **Summary**: Some forces appear to have structures in place to learn lessons and keep the prevention of deaths in custody at the forefront of the minds of staff. However, very few responses referred to how learning was shared between forces or described the liaison with and learning from bereaved families, and none referenced the role disproportionality and race may play in this area. We believe that forces and policing bodies should do more to share learning across the UK's 43 policing areas in these vital areas of focus.

30. 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 deaths across police forces, which are all operationally independent from one another.

31. 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.

    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 Independent Office for Police Conduct (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. 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.

    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. 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:

32. 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.

33. 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.

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

34. 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.[16] We understand 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 report into deaths and serious incidents in custody by Dame Elish Angiolini KC.[17] 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.

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

36. 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.

37. 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.

38. Further, while reference was made in the information-gathering exercise to the use of force and disproportionality, input on these points was minimal. This omission is a matter of concern. We urge individual forces, the Home Office, the NPCC, the IOPC, and the College of Policing to take active steps to build and disseminate a greater understanding of the role of disproportionality and race in relation to deaths in police custody. 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). This goes to the heart of what it means 'getting the basics of policing right': protecting lives by stopping deaths in police custody, but ensuring greater trust between police and the communities they serve, particularly those of BAME backgrounds.

Conclusion

39. Preventing deaths in connection to police custody is vital to getting the basics of policing right. Deaths that do occur are largely preventable, and more needs to be done to identify and take forward good practice to reduce the number of deaths to zero. We have identified a range of initiatives being taken forward by police to highlight the partnerships they have built with allied health and justice services to play to professional strengths and reduce inappropriate use of police time. At the same time, our evidence identifies significant gaps in practice relating to our identified priority areas, as well as extensive opportunities to better embed and share learning after deaths in custody. A full, separate report analysing this evidence will shortly be published by the IAPDC. The IAPDC will then work with new Ministers, the Ministerial Board on Deaths in Custody and policing partners to disseminate and

address its findings. The IAPDC would be pleased to provide further information to this inquiry by the Home Affairs Select Committee.

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