

Death in or following Custody

A briefing for Schemes and ICVs

At scheme request, ICVA has been asked to produce a briefing for schemes and ICVs regarding what happens when there has been a death in or following police custody. This briefing should be read along with the Association of Police and Crime Commissioners guidance which you can find [here](#). It also takes account of the [NPCC guidance for preventing suicides in and following police custody](#) (Oct 2025). The points for ICVs to monitor also include themes from Prevention of Future Death reports (PFDs).

OPCCs (and their equivalents) will have varying arrangements in terms of being notified of deaths in or following custody. Most schemes will be made aware of a death occurring in a custody suite. ICVA shares a briefing specifically designed with the IOPC for sharing with ICVs where a death in custody has occurred and ICVs have had contact with the detainee. Some schemes may also be made aware of if there has been a death following custody.

This briefing is designed to frame how ICVs can tailor their monitoring where there has been a death in or following police custody.

It is important to note that whilst information sharing and monitoring are key to prevent ill treatment and ensure appropriate treatment and conditions for detainees, where there has been a death in custody, it is very important that ICVs or any staff of the OPCC and their equivalents do not interfere in resultant investigations.

The role of the IOPC

The 'appropriate authority' (e.g. a police force) must refer to the IOPC all 'Death and Serious Injury' (DSI) matters. A DSI matter means any circumstances in, or as a result of which, a person has died or sustained serious injury and:

- at the time of death or serious injury the person had been arrested by a person serving with the police and had not been released or was otherwise detained in the custody of a person serving with the police; or
- at or before the time of death or serious injury the person had contact of any kind - whether direct or indirect - with a person serving with the police who was acting in the execution of his or her duties and there is an indication that the contact may have caused - whether directly or indirectly - or contributed to the death or serious injury.

Once an incident has been referred, the IOPC decides whether the matter should be investigated. If it decides that it should be investigated, then it must determine the mode of investigation. It may choose to conduct its own independent investigation, direct a police investigation, or decide that the matter can be investigated locally by the police. If the IOPC decides no investigation is required, it may refer the matter back to the force to handle the matter in whatever reasonable or proportionate manner it determines.

Prevention of Future Death Reports (PFDs)

A PFD, sometimes called a Regulation 28 report, is issued by a coroner when they believe that actions should be taken to prevent further deaths in similar circumstances. In the context of a death in police custody, this means the coroner has identified concerns such as unsafe practices, inadequate risk management, or failures in communication or healthcare provision. The report is sent to the relevant police force or organisation, who must formally respond with what improvements they will make. PFD reports are an important part of accountability and learning in custody, ensuring that risks are addressed and future harm is reduced.

ICVA shares all details of PFDs relevant to police custody in newsletters, and ICVs and schemes are advised to read these, and consider arrangements in their own scheme from the learning.

OPCAT and prevention of deaths in police custody

Although OPCAT does not specifically reference “deaths in custody”, its preventive framework is expressly designed to reduce the risk of serious harm, including deaths, in all places of detention. OPCAT requires regular, independent monitoring of detention, full access to detainees and records, and the ability to identify and report systemic risks to life — such as failures in medical care, observation, or use of force.

In the UK, Independent Custody Visitors are part of the National Preventive Mechanism established under OPCAT, and their continued scrutiny of custody procedures is a key means by which local practice is improved and future harm prevented.

What can ICVs do?

Independent Custody Visitors (ICVs) play a vital role as the community’s “eyes and ears” inside custody. ICVs can help reduce risk by monitoring the following areas:

Risk Assessment & Monitoring

- Risk assessments are individualised, updated, and reflect changing behaviour
- Observation levels match risk and are being conducted correctly
- Meaningful staff engagement with detainees is evident
- Signs of emotional distress are being noticed and escalated

Safe and Supportive Environment

- Cells are clean, comfortable, and dignity is respected
- Detainees have access to distraction, fresh air, communication

Healthcare Access

- Healthcare Professionals (HCP) are accessible when needed and promptly
- Medication continuity is maintained where possible and subject to risk assessment
- Alcohol/drug withdrawal risks actively monitored

Information Sharing

- Detainees understand rights and custody process
- Appropriate Adults are requested where needed
- Communication is compassionate and accessible

Pre-release

- Access to family/friends is supported where appropriate
- Post-release vulnerability is considered in pre-release risk assessment
- Referral pathways (L&D, drug/alcohol services, veterans, etc.) are used

High-Risk Groups

- Sexual offence suspects
- People with restrictive bail conditions (e.g. detainee unable to return to family home)
- Veterans
- Notifiable occupations (such as teachers)
- Those experiencing homelessness or major life crisis

ICV Checklist

- ☐ Is a detainee showing signs of distress, confusion, or suicidal thoughts?
- ☐ Is the risk assessment up to date and aligned with behaviour?
- ☐ Are observation levels appropriate and documented?
- ☐ Has a Healthcare Professional been called where needed?
- ☐ Do they have access to medications they might need at the right times?
- ☐ Is an Appropriate Adult present if required?
- ☐ Are communication and dignity prioritised?
- ☐ Have vulnerabilities and high-risk factors been considered in pre-release risk assessments?

What can ICVs do if they are concerned about someone, either whilst they are in custody, or on their release?

1. Raise the concern immediately with the Custody Sergeant and/or escorting officer
2. Record the concern in the visit report
3. Follow escalation channels via the Scheme Manager if risk is ongoing

It is important to note that we do not expect ICVs to provide clinical/psychological judgement but that ICVs **absolutely should** raise concerns if they believe a detainee is unsafe or not receiving proper care.

You might find this briefing on [speaking with detainees experiencing mental ill health](#) useful in terms of your approach.

Briefing Ends.