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4th March 2025

Dear Dr Nicolas Shaw

Thank you for including the NPCC Custody portfolio within your prevention of future deaths report concerning Mr Matthew Brierley.

[redacted]and I, took over the Custody portfolio in October 2024 and the overarching priority behind all of our strategic objectives, is to make custody as safe as possible for detainees and those working within the custody environment. To that end, we are heavily involved with the healthcare providers and what is often referred to as, Liaison and Diversion services within custody. We recently re-established the healthcare providers working group and meet regularly with the IOPC, and also attend the Ministerial Board on Deaths in Custody, working to prevent both deaths in custody and post custody suicides. Today, I have also attended a national meeting of police, healthcare providers and stakeholders including the Independent Office of Police Conduct, Independent Custody Visiting Association, Independent Advisory Panel on Deaths in Custody, College of Policing and others, where I raised the death of Matthew as a primary example of what it is we are working to improve.

I detail the aforementioned with the intention of making you aware of the importance this portfolio places upon all deaths in or following custody.

The death of Matthew is an extremely tragic example of where improvements are required. I will address each of your matters of concern in turn.

1 and 3 – A lot of research has been undertaken already, to try and identify any commonalities between instances of post custody suicide. The objective is to establish a post release risk assessment process that will identify those most at risk, and initiate a process to mitigate that risk, with further support such as a mandatory referral to support agencies. The current research has identified from a review of five years of data from the IOPC:

439 deaths
288 occurred within 48 hours of release
151 occurred outside 48 hours of release

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The next phase of the research discussed today, will be for each force from which one of those deaths occurred, to answer further qualitative questions to identify commonalities. At present, we do not ask the key questions that identify the impact upon somebody's life, following their arrest. Questions proposed include subjects such as:

Did they have to change their place of residence as a result of bail conditions?
Was their access to children restricted?
Was their employer notified?

These were all applicable to Matthew.

Answers to these and other questions, will be analysed to draw any statistical conclusions available, that can then be used to identify those most at risk in the future. The timetable for this next stage of research, is to submit the request to all forces by the end of April and allow 4 months for the return of the requested information. Once received, the analytical work will be undertaken, with a time estimate of 6 months. Whilst this work will take time to complete, communication with strategic custody leads is conducted via a quarterly strategic board meeting and the regular sharing of information and guidance such as the findings within this report and others, so as not to delay any learning.

I note in Matthew's case, he was offered support, which he declined, but as aforementioned, we are seeking to introduce an evidence led process to identify individuals where a mandatory referral to partner agencies for support following a release from custody is made, so the onus is not on the individual to accept the support offered during their detention, as it is recognised many individuals will decline this for different reasons as you have outlined.

2 – In relation to the examination of digital devices, timescales vary between forces, but it is not uncommon for those considered to be linked to lower risk investigations, not to be processed for many months. It will be for the officer in charge (OIC) of the investigation to identify all risks within their submission to their Digital Forensics Unit (or equivalent), which is then used to prioritise the examination of those devices. The factors in this investigation should have resulted in a much quicker interrogation of the device than the 18 months estimated. The fact that Matthew was on bail, should have seen the investigation progressed within the requisite bail periods, but I cannot comment upon any individual backlogs or otherwise that the force concerned may have been managing. It appears however, that the risk of suicide was not weighted heavily enough in any triage of the mobile device that took place.

Assessments of risk should always be individualised. Whilst there will be a question set used to conduct a pre-release risk assessment, the responses should be applied to the individual circumstances of the investigation, by the OIC and ratified by their supervisor when making a disposal decision. Bail conditions should only be applied where it is necessary and proportionate to do so. There is a

presumption for unconditional bail, unless conditions are required to manage the risk of further offences, interference with witnesses or ensure the suspect attends future proceedings.

I have shared a copy of this prevention of future deaths report with all custody leads within the UK, with a recommendation to ensure that the risk of suicide within cohorts such as Matthew's, are included within the investigative strategies and particularly the triage of digital devices, and that risk assessments are tailored to the individual circumstances of the investigation.

I hope the contents of this letter have been useful and offer some reassurance of the ongoing work and seriousness [redacted] and I place on all instances of post custody suicide. Please do contact me if I can be of any further assistance.

Yours faithfully,

[redacted]