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INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

Welcome to the eleventh E-bulletin from the Independent Advisory Panel (IAP) on Deaths in Custody, which provides an update on the work that has been taken forward by the Panel since March 2013.

In April 2013, the Panel met with the Care Quality Commission (CQC) to discuss a number of findings from the Panel's second IAP statistical analysis of all recorded deaths in state custody. In May and June 2013, the Panel also had a number of productive meetings with the Prisons and Probation Ombudsman (PPO); the Chair of the CQC; NHS England and the Association of Police and Crime Commissioners.

In June, the Panel met the Independent Police Complaints Commission; Her Majesty's Inspectorates of Prisons and Constabulary; College of Policing and the Association of Chief Police Officers (ACPO) to discuss the Panel's work on developing a justification for police forces to collate use of force data. The Panel believe that it is crucial to evidence how many times use of force occurs in order to improve our understanding of the situations which led to the use of force, identify any safety issues, and to highlight good practice that could be shared across the sectors. It was agreed that the IAP would feed into the revisions to the ACPO Safer Detention and Handling of Persons in Police Custody guidance to determine what kind of data requirements there should be for use of force recording and to identify mechanisms to better extract this data for analysis.

The Panel have also been tendering for an organisation to deliver a two year programme of research. Following an open and transparent process, a consortium of the University of Greenwich and the Runnymede Trust were awarded the contract. The Panel look forward to working with the research team for the next two years.

In June 2013, the Ministerial Board on Deaths in Custody met for the thirteenth time and was chaired by Damian Green, Minister of State for Policing and Criminal Justice. The Panel presented their analysis of Serious Untoward Incident reports and the common principles for safer restraint, both of which were were endorsed by the Board. The Panel will now be working with relevant organisations to take these pieces of work forward.

As always, should you wish to comment on any of the issues raised or have any questions, please contact the Secretariat who will pass them on to me and the other members of the Panel.

Thank you,

Toby Harris

CONTENTS

Meetings with the Care Quality Commission (CQC)

The Panel met with the CQC in April 2013 to discuss findings from the IAP's statistical analysis of recorded deaths between 1 January 2000 and 31 December 2011. CQC confirmed that work was underway to link the Mental Health Minimum Dataset, which includes details of all detained patients with hospital episode statistics, which detail all deaths in health and social care settings to improve the recording of causes of death. CQC also confirmed that they were not aware of any particular vulnerabilities and risks for detained female patients, however they did have the resources to undertake a thematic review in this area, if concerns were raised by providers.

CQC also raised concerns about the lack of national accredited guidance on the use of restraint in health and social care settings, which made it difficult for service providers to develop a consistent and safe approach to the use of restraint and to train staff accordingly. There was therefore no single set of standards in place around the use of restraint against which regulatory judgments can be made.

CQC are in the process of developing a series of risk indicators to assure their governance processes. This work has yet to be started, but they would consider including natural cause deaths and female detained deaths as potential indicators to flag greater focus from CQC.

Lord Harris also had a follow up meeting with David Prior, Chair of the CQC on 10 June 2013.

Meeting with NHS England

Lord Toby Harris met with Dr Mike Durkin, Director of Patient Safety at NHS England in May 2013. Dr Durkin was supportive of the IAP's analysis of Serious Untoward Incident reports and their work on devising common principles for safer restraint. There was a discussion on CQC's concerns about the lack of nationally accredited restraint standards. Dr Durkin said that a key priority for NHS England would be to develop guidance for Trusts and commissioners on the management of challenging behaviour.

The functions of the National Reporting and Learning System Safety Agency were dispersed when the National Patient Safety Agency (NPSA) was disbanded. The Patient Safety Directorate is currently in the process of re-instating those functions and one of their key aims will be the development of an integrated reporting system, which will incorporate a learning capture and dissemination mechanism. They will be working with the NHS Information Centre to achieve these aims.

The Panel will be seeking a meeting with Kate Davies, Head of Public Health, Offender Health and Military Health and Ann Sutton, Director of Commissioning later in 2013 to explore NHS England commissioning of healthcare in custodial establishments.

Meeting with the Prisons and Probation Ombudsman

Lord Harris met with Nigel Newcomen, the Prisons and Probation Ombudsman (PPO) in June 2013 to update him on some of the current projects the Panel were

undertaking including the common principles for safer restraint; family liaison standards and the IAP research contract. The University of Greenwich and Runnymede Trust (who were awarded the contract, further details are provided below) will be engaging with the PPO learning team to utilise their expertise in investigating deaths in prisons; approved premises; young offender institutions and immigration removal centres.

There was also a discussion on the joint clinical review pilots. Further details are included later in the E-bulletin.

Meeting with Chair of the Association of Police and Crime Commissioners

Lord Harris also met with Tony Lloyd, the Chair of the Association of Police and Crime Commissioners (APCC) in June 2013 to discuss some of the Panel's projects which have relevance to police forces in England and Wales, including:

- the development of a justification for requiring police forces to submit use of force data for central analysis;
- the development of common principles on the safer use of restraint in custody.
- reviewing the role of mental illness in deaths in custody;
- the use of Section 136 of the MHA;
- the development of an information sharing statement to improve the flow of detainee's self harm, risk of suicide and healthcare information as they move through the criminal justice system and;
- the development of a common approach to improve family liaison services following deaths in all custodial settings

IAP research contract

In early 2013, the Panel ran a tender process to procure an organisation to deliver a programme of research and analysis on behalf of the Panel from 2013/14 to 2014/15. This will enable the Panel to develop a stronger evidence base for reducing deaths in all state custody and to enhance IAP recommendations made to the Ministerial Board.

Following an open and transparent process, the University of Greenwich and the Runnymede Trust were awarded the contract in June 2013, with work commencing in July 2013. Currently, the following research deliverables have been identified which will feed into the existing IAP projects:

1. A systematic review of the role of mental illness and deaths in all state custody. This will involve identification of key research and literature on the subject and a critical analysis of the findings to draw out themes on which the Panel should concentrate its efforts in future.
2. Standardisation of data on deaths in custody in all settings by age, gender and ethnicity to allow comparison between settings and years.
3. The design a methodology for evaluating the impact of the Panel's information sharing statement (about risk of self harm) on practitioner behaviour and to make recommendations for improvement.
4. Assessment of the efficacy of information sharing between YOTs and custodial settings for assessing and managing the risk of self harm and suicide by children and young people.
5. Examination of data on protected characteristics of those that have died in custody to make suggestions for improved practice in relation to specific groups.

6. Other projects are subject to confirmation but might included: examining the effectiveness of the Assessment Care in Custody and Teamwork (ACCT) in prisons and equivalent processes in other settings for managing risk of self-inflicted deaths; and evaluating restraint training packages in place across the custodial sectors.

The Panel met with the consortium on 4 July to agree milestones and stakeholder engagement strategies. The research organisation is keen to engage with the Panel's stakeholders and if you would like to be involved in this process, please contact Alice Balaquidan on **Alicia.balaquidan@noms.gsi.gov.uk.** It is the Panel's aim to present the research outputs to the Ministerial Board through the duration of the research contract. An update on the progress of the research will be provided in the November E-bulletin.

Ministerial Board on Deaths in Custody

The thirteenth meeting of Ministerial Board on Deaths in Custody was held on Thursday 20 June 2013 and was chaired by Damian Green, the Minister of State for Policing and Criminal Justice. Professor Philip Leach presented his analysis of a sample of redacted Serious Untoward Incident (SUI) reports to determine their compliance with Article 2 of the European Convention on Human Rights and Professor Richard Shepherd presented his common principles for the safer use of restraint. Further details about these items can be found in the **IAP update section**. Lord Harris also provided an update on implementation of IAP recommendations made to the Ministerial Board.

The Mayor's Office for Policing and Crime presented a paper on a pilot to monitor the use of physical restraint in police custody suites throughout London. The Department of Health (DH) provided an update on the progress of the liaison and diversion scheme, which seeks to strengthen the early identification of people with mental health problems or learning disabilities and divert them from the criminal justice and into more appropriate treatment centres and Her Majesty's Inspectorate of Constabulary (HMIC) presented their joint thematic examining the use of police custody as a place of safety for detainees subject to Section 136 of the MHA. There was also a further discussion from the Prison Reform Trust and INQUEST on 'Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison'.

The Prisons and Probation Ombudsman (PPO) presented their Learning Lessons Bulletins **(available to download here)** and additional updates were also heard from the National Offender Management Service (NOMS) and DH on progress with implementing the recommendations from the review of unclassified prisoner deaths in 2010/11 **(the review is available to download here)**. INQUEST also highlighted the Advisory Board on Women Prisoners.

Update on IAP Projects

Below is a summary of the progress made by the IAP since the last E-bulletin:

Cross sector learning and coroner reform – Deborah Coles

The Chief Coroner was due to attend the IAP meeting in March 2013 to discuss progress on the IAP's recommendations with relevance to his office, however due to training commitments, he was unable to attend. The recommendations concern training for coroners;

identifying appropriate recipients to Rule 43 reports and the development of a fully searchable and publicly accessible database for all Rule 43 reports to promote learning from deaths in custody. The IAP looks forward to meeting with the Chief Coroner once his office is fully staffed to discuss the recommendations and any other shared interests.

Article 2-compliant investigations – Professor Philip Leach

The PPO ran a joint pilot with the NHS for ten weeks from April 2012 on a new approach to clinical reviews. The pilots, in the North of England and South of England NHS areas, tested a more robust process for conducting reviews and on developing an effective system for sharing learning. The pilots resulted in improvements to clinical review delivery, with 39% of reviews in the pilot studies delivered on time, compared to 9% of non-pilot cases.

The remaining NHS areas adopted the pilot approach at the beginning of April 2013. The pilots have also resulted in new guidance being jointly issued by the PPO and NHS England intended to improve the quality of the reviews by ensuring that they are appropriately thorough and focussed on relevant issues. The Panel welcome these improvements and will continue to monitor whether they have a long term impact.

Investigation of deaths of detained patients

The IAP have a particular focus on improving the provision of Article 2-compliant investigations of deaths in custody and identified that independent investigations into the deaths of detained patients were not being undertaken by Strategic Health Authorities (SHAs). The CQC provided a sample of redacted SUI reports from Trusts to the Panel, which were analysed using a number of criteria under the broad descriptions of an Article 2-compliant investigation, that is it should be: (1) initiated by the state of its own volition; (2) independent; (3) effective; (4) sufficiently open to public scrutiny; (5) reasonably prompt and; (6) the next of kin / family should be involved.

The analysis – which was presented to the Ministerial Board in June and can be **downloaded here** - highlighted the variable quality and consistency of the 18 redacted SUI reports. Terms of reference for reviews were not clear in most of the sample and only three reports stated that families were involved in setting the terms of reference. Most cases involved a review of case records and policies and in ten of these cases, the reviewers interviewed staff. The management and treatment of patients' physical health was examined in six cases although none involved a full clinical review of the patient, as would be the case when a prisoner dies and the Prisons and Probation Ombudsman (PPO) is investigating. In nine of the cases included in the sample, there was a clear offer to families of involvement in the review, with no specific mention made in eight cases. None of the reports were published and thus not subject to public scrutiny. Reviews were completed promptly, on average taking three months to conclude.

The analysis highlighted that there was no satisfactory system for independently investigating the deaths of patients detained under the Mental Health Act. Whilst the Panel agreed with the Government that inquests are the primary means by which the state discharges its duties to investigate deaths in custody, it was important to emphasis that the nature and extent of the investigations carried out pre inquest are of critical importance as these are used to inform the inquest.

Given the variable quality of the sample, it was the Panel's view that NHS England – with input from CQC and the Chief Coroner - should produce guidance for mental health trusts, which provides clear and consistent guidance on how trusts should undertake investigations following the death of a detained patient (which should include guidance on how to ensure investigations are Article 2 –compliant, where relevant). The Board endorsed the recommendation and the Panel will now take this forward with relevant organisations, providing an update to the Board in October.

The CQC identified a potential gap relating to the Strategic Executive Information System (STEIS). Currently, STEIS does not record SUIs – either in terms of suicides or other incidents – for patients detained under the MHA. The lack of recording of this group creates difficulties as providers are not held to account robustly by their commissioners for the quality of investigations following a death and subsequent implementation of any actions / recommendations. Therefore, there was no clear system centrally for determining when an investigation should be triggered. The Panel will explore this gap further with CQC and NHS England and will provide an update in the November E-bulletin.

Use of physical restraint – Professor Richard Shepherd

The Panel presented their common principles for the safer use of restraint at the Ministerial Board on 20 June. The principles cover expectations for restraint training; the management of a restraint incident; medical conditions relating to the use of restraint and governance procedures such as de-briefing and data collation. These were endorsed by the Board and it is the Panel's intention to publish these as a statement of what it believes to be a safer way to manage use of physical restraint, and to prevent deaths.

The principles, available to download from the **IAP website here** have been proactively communicated to the practitioner and stakeholder group. Custodial organisations, investigatory and regulatory bodies have also been asked to implement the principles using their own communication channels and policy approval methods and have also been communicated to a number of third sector organisations and monitoring bodies. The Panel will engage with operational staff in the custody sectors to see if it is readily digestible and to identify if it will improve restraint practices. An update on this work will be presented to the Ministerial Board in October 2013

Following the meeting with police practitioners and the IPCC in March 2013, the IAP held a positive meeting with HMIC; Her Majesty's Inspectorate of Prisons; Independent Police Complaints Commission; College of Policing and the Association of Chief Police Officers on 13 June to discuss the Panel's work in developing a justification for requiring police forces to submit use of force data for central analysis. Attendees agreed that whilst significant data was held local police databases on use of force incidents', accessing the data for analysis was difficult as this was contained in the custody record's and would require a manual trawl.

The ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody is currently being revised as this does not cover the period between the point of arrest and when an individual enters the police custody suite. It was agreed that the IAP, IPCC, HMIC and HMIP to feed into the current revisions to determine what kind of data requirements there should be for use of force recording and to identify

mechanisms to better extract this data for analysis. The Panel will provide an update on this work to the Ministerial Board in October 2013.

Staffing update

Claire Johnson was appointed as the new Head of Secretariat on 3 June 2013 and Matt Leng will be leaving the Secretariat on 2 August 2013.

Practitioner and stakeholder group

There are now over 150 members of the practitioner and stakeholder group, drawn from inspectorate and investigative bodies, lawyers, Third Sector organisations, families, academics and practitioners from the custodial sectors. The Panel would like to encourage practitioners from a range of organisations, particularly mental health settings, as well as families to join the group. If you would like to join, please contact **Alice Balaquidan on alicia.balaquidan@noms.gsi.gov.uk.**

IAP learning library

The Secretariat acts as a hub for the sharing of learning and information about the means of preventing deaths in custody. In June 2011, the Secretariat launched the IAP's Learning Library, which contains learning documents from the criminal justice agencies and third sector organisations which may have cross sector applicability. If you think there are documents that should be included in the library, please contact the Secretariat via **iapdeathsincustody@noms.gsi.gov.uk**.

Contributing to the IAP's website

The IAP's intention is that everyone with an interest in preventing deaths in custody should have the opportunity to contribute to the IAP's work. If you have a relevant news story or research article that you feel may be of particular interest to stakeholders, please feel free to contact the Secretariat at: **iapdeathsincustody@noms.gsi.gov.uk.**

News

Safety in Custody Statistics England and Wales Update to March 2013

The Ministry of Justice and the National Offender Management Service (NOMS) have published their quarterly statistical bulletin on deaths, self harm and assaults in prison custody. http://iapdeathsincustody.independent.gov.uk/news/safety-in-custody-statistics-england-and-wales/

Coroner Services in England and Wales

The Ministry of Justice have announced the launched of the new guidance for coroners. http://iapdeathsincustody.independent.gov.uk/news/coroner-services-in-england-and-wales/

IAP common principles for safer restraint

The IAP have published their common principles for safer restraint. These were endorsed by the Ministerial Board on 20 June 2013. http://iapdeathsincustody.independent.gov.uk/news/iap%e2%80%99s-common-principles-on-the-safer-use-of-restraint-published-today/

IPCC report into deaths during or following police contact 2012/13

The IPCC have published their latest statistics. http://iapdeathsincustody.independent.gov.uk/news/ipcc-report-into-deaths-during-or-following-police-contact-statistics-201213/

National Confidential Inquiry report into suicide and homicide by people with mental illness

The NCI have published their latest annual report.http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf

Latest IAP Death in Custody Parliamentary Log

The Independent Advisory Panel (IAP) on Deaths in Custody Parliamentary Log provides a summary of all Parliamentary business concerning deaths in state custody since 1 April 2009. The log includes information on Parliamentary Questions and Debates, and Written Ministerial Statements from the UK Parliament and devolved assemblies.
http://iapdeathsincustody.independent.gov.uk/news/iap-death-in-custody-parliamentary-log/

IAP publish its analysis of redacted Serious Untoward Incident (SUI) reports

Professor Philip Leach presented his analysis of 18 redacted Serious Untoward Incident to the Ministerial Board meeting on 20 June 2013.
http://iapdeathsincustody.independent.gov.uk/news/iap-publish-analysis-of-redacted-sui-reports/

Joint thematic review of Section 136 of the Mental Heath Act (MHA) published

Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and the Healthcare Inspectorate Wales have published a report on their review on the use of police cells as a place of safety for people with mental health needs. The review examines the extent to which police custody is used as a place of safety under section 136; and identifies the factors which either enable or inhibit the acceptance of those detained under section 136 into a preferred place of safety, such as a hospital or other medical facility.
http://www.hmic.gov.uk/publication/a-criminal-use-of-police-cells/

Mind's report on physical restraint published

Mind has published a report on physical restraint which sets out Mind's findings on the use and impact of physical restraint in mental healthcare settings in England.
http://www.mind.org.uk/campaigns_and_issues/current_campaigns/care_in_crisis/report_on_physical_restraint

A new report from INQUEST: Preventing the deaths of women in prison

INQUEST has published a report on the deaths of women in prison.
http://www.inquest.org.uk/pdf/briefings/INQUEST_Preventing_deaths_of_women_in_prison.pdf

MoJ published reports made under Rule 43 of the Coroners Rules

In June, the Ministry of Justice (MoJ) published its summary of reports and responses under Rule 43 of the Coroners Rules. Between 1 October 2012 and March 2013 coroners in England and Wales issued 235 Rule 43 reports. This is the ninth report issued by the Ministry of Justice and contains details of death in custody cases.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/204786/9th-rule-43-report.pdf

Coroners statistics 2012 England and Wales published

In May, the Ministry of Justice published the Coroners Statistics 2012 for England and Wales. The bulletin presents statistics of deaths reported to coroners in England and Wales in 2012 including inquests held

and verdicts returned at inquests.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199793/coroners-statistics-bulletin-2012.pdf

Independent commission published mental health and policing report
The Independent Commission on Mental Health and Policing published their report on how the Metropolitan Police Service (MPS) interacts with people with mental health problems. The commission, led by Lord Victor Adebowale, was set up on the request of the Metropolitan Police Commissioner in September 2012 to review the work of the MPS with regard to people who have died or been seriously injured following police contact or in police custody. The report contains 28 recommendations, which fall under three areas for action: (1) Leadership (2) On the frontline (3) Working together: interagency working
http://www.wazoku.com/wp-content/uploads/downloads/2013/06/Independent_Commission_on_Mental_Health_and_Policing_Main_Report.pdf

Independent investigation into the case of 'AB' published
The independent investigation into the life-threatening self-harm of AB at HMP Bedford on 24 June 2008 had been published, along with the response to the investigation from the National Offender Management Service (NOMS).
http://iapdeathsincustody.independent.gov.uk/news/independent-investigation-into-the-case-of-ab-published/

IAP meeting 8 May 2013
The eighteenth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place on Wednesday 8 May 2013. At this meeting, the Panel received updates about the IAP research tender and the IAP national stakeholder conference, discussed their IAP projects in relation to the analysis of serious untoward incident reports following deaths of detained patients, the physical restraint common principles, the summary of Rule 43 recommendations, the quarterly deaths in custody data and the preparation for the Ministerial Board in June 2013.
http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-8-may-2013/

Safety in custody statistics in England and Wales update
The Ministry of Justice and the National Offender Management Service (NOMS) published their quarterly statistical bulletin on deaths, self harm and assaults in prison custody. The publication updates statistics up to the end of 2012 for England and Wales. NOMS monitors deaths, self-harm and assaults in prisons and has a range of related measures to help monitor overall safety.
http://iapdeathsincustody.independent.gov.uk/news/safety-in-custody-statistics-in-england-and-wales-update-to-december-2012/

Next Issue

The next e-bulletin will be published in November 2013.