INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

Welcome to this longer e-bulletin from the Independent Advisory Panel (IAP) on Deaths in Custody. This twelfth edition provides an update on the work that has been taken forward by the Panel since the last bulletin in July 2013.

You will have noted that there has been no bulletin in the last twelve months which has been due mainly to staff changes and vacancies. However, the Secretariat is fully staffed again so you can expect to receive these bulletins on a more regular basis.

The last twelve months have been time of great change. We have new Panel members, moved forward with several of our projects and taken on extra work.

Three of our original members retired from the Panel in April 2014. It was with sadness that we said goodbye to Simon Armson, Professor Stephen Shute and Dr Peter Dean. All three had been with the Panel since its inception in 2009. On behalf of the Panel I would like to thank them for their commitment and contribution to progressing the work of the Panel.

In their place I would like to introduce our five new Panel members, Matilda McAttram, Dinesh Maganty, Meng Aw-Yong, Stephen Cragg and Graham Towl. I welcome them all to the Panel and look forward to working with them. Short biographies of all the panel members can be found **here**.

Earlier this year the Panel was asked by Jeremy Wright, the Minister for Prisons and Rehabilitation, to conduct an Independent Review into the Self-inflicted Deaths of Young Adults in NOMS Custody. This is an important piece of work, which will deliver learning not just for 18-24 year olds but across the age ranges and will necessarily require a lot of Panel involvement over the next year before its completion in March 2015.

There have been changes to the Secretariat as well; I am pleased to welcome back Laura McCaughan from maternity leave, and new member Kishwar Hyde. Their addition brings the Secretariat up to full complement.

The University of Greenwich research team are delivering projects for the Panel on a number of topics, including production of the statistical report on deaths in custody for 2012. They will shortly complete a literature review on mental disorders and deaths in custody.

The Panel held a very successful stakeholder consultation event in March 2014. You can find information about this and more detail about our projects in this bulletin.

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

IAP Stakeholder Event

The third IAP stakeholder consultation took place on 27 March 2014. The Panel were pleased to note that over 100 stakeholders attended the event, which was held in London.

The event was opened by Lord Harris, Chair of IAP, who emphasised the importance the Panel places on engaging with stakeholders. He went on give a brief overview of the Panel's achievements during their second term.

The Prisons and Rehabilitation Minister, Jeremy Wright, gave the key note speech. He acknowledged the Panel's successes, spoke about the Government's continuing support and commitment to the Panel and the wider Ministerial Council and shared what was being done in prisons to prevent deaths

The theatre company Cleanbreak then gave a short performance to engage attendees on the subject of deaths in custody. The actors stayed in role during the themed break-out sessions to talk about their experiences of custody as a way of promoting open discussions and to explore the issues in greater depth.

The day was rounded off with an opportunity for attendees to comment on learning, to share any insights arising from the day, and to comment on wider issues related to deaths in custody that might be relevant to the IAP for the remainder of their term.

Feedback from the event was positive, with most attendees stating that they had been pleased with the arrangements and the content of the day.

"*Very good - Lots of opportunity to contribute. Good cross section of delegates with relevant expertise.*"
Event delegate

"*the Cleanbreak presentation and facilitation was excellent.*"
Event delegate

"*really liked the theatre approach. Would like more thinking around case study. Great to discuss with your eminent panel.*"
Event delegate

The Panel is now considering how they might take forward suggestions for new priorities suggested by stakeholders.

IAP research contract

In early 2013, the Panel ran a competition to procure an organisation to deliver a programme of research and analysis on behalf of the Panel from 2013/14 to 2014/15.

The University of Greenwich and the Runnymede Trust Consortium were awarded the contract, with work commencing in July 2013. The Panel have met with the consortium regularly to agree individual project plans and to discuss draft reports. Additional quality assurance support is provided to the Secretariat by NOMS research governance. The Panel will be publishing a number of research and analysis outputs after presentation to the Ministerial Board through the duration of the research contract.

The research team have to date delivered the following projects:

(i) An evaluation of the impact of disseminating the Panel's information sharing statement (about risk of self harm) on practitioner behaviour. The Panel are considering how best to take forward the recommendations for improvement. The evaluation document can be found **here**.

Examine 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. The document can be found **here**.

(ii) A statistical analysis report of recorded deaths 2000 to 2012. Please see feature on **page 7**.

Work is underway to complete a literature review on the role of mental disorder and deaths in custody and to prepare for the next edition of the statistical analysis covering deaths up to the end of 2013.

Update on IAP Projects

Use of Physical restraint

(led by Prof Richard Shepherd)

Common Principles

Following endorsement of the Panel's common principles for the use of restraint across all custodial sectors by the Ministerial Board in June 2013, the principles were published in July 2013. They 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. The principles were published **here**.

Custodial organisations, regulatory bodies such as the Care Quality Commission and the Department of Health have responded positively to the principles although there is more to be done to address provision of training and recording of the use of restraint. The Panel will be following up on how the principles are being implemented during 2014.

In April 2014, the Department of Health published their guidance, "Positive and Proactive: Reducing the need for restrictive interventions". The importance of recording and monitoring of restraint incidents is noted in this guidance. In addition, NHS England is developing guidance on recording the use of restraint in relation to patient safety. It is hoped that recording use of restraint

on the National Reporting and Learning System (NRLS) will improve learning and good practice. NHS England is also developing a safety thermometer for restraint which could be applicable in a number of settings.

The Panel welcomes these developments and will consider them closely as well as working with the relevant organisations to examine how its principles are being implemented in practice.

Use of Force in Police Custody

In June 2013 and February 2014 the Panel met with 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 progress the Panel's work in developing a justification for police forces to submit use of force data for central analysis.

The revision of ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody as Authorised Professional Practice (APP) disseminated by the College of Policing provides an opportunity to change the definition of custody to cover the period from the point of arrest as well as the police custody suite. As part of the work to revise the guidance, ACPO have considered how forces record use of force data and have worked with the IAP to determine the data requirements to be included in the APP.

The consultation on the revised APP on Detention and Custody was launched on 24 June 2014. The Panel will be submitting a response and will publish it on our website. The consultation can be found **here**.

Information Flow through the Criminal Justice System

(previously led by Professor Stephen Shute)

Person Escort Record (PER)

The Panel continues to monitor implementation of the recommendations made in Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Prisons Joint Review, "The Use of the Person Escort Record with Detainees at Risk of Self-Harm". The review can be found **here**.

Information sharing statement (ISS)

In 2013 the University of Greenwich consortium carried out a preliminary evaluation of the perceived impact of the Information Sharing Statement (ISS) following its dissemination by organisations in 2012. Those who had originally been sent the statement (or those who had taken over for those roles) were contacted and a series of interviews conducted which explored how important information typically flowed in the organisation, how the information statement was disseminated, and whether they believed that the ISS had had an impact on practice. The investigation found that there was great variation across the organisations in the methods of cascading the information and it was quite likely that ground level staff would not have seen the ISS.

Lord Harris circulated the consortium's report and recommendations to the Ministerial Board in February 2014; he acknowledged a consensus that poor information sharing was consistently indicated in deaths in custody and that more effort may be needed to ensure the changes are implemented in a practical way. The Board agreed that the information sharing statement should be disseminated again to ensure that those on the ground were aware and could implement it. Panel members discussed the approach at their meeting in May, and have suggested that instead of simply re-issuing the guidance, it would be helpful for the IAP to meet service leads to agree the best way

of ensuring implementation in each organisation to support staff to change their behaviour and improve practice. The Panel will be following this up in the coming months.

Assessment Care in Custody Teamwork (ACCT)

ACCT is the key process used in prisons to identify and manage the risk of self-harm and suicide.

In 2013 the Panel asked the University of Greenwich to scope the effectiveness of ACCT in prisons and equivalent processes in other settings for managing risk of self-inflicted deaths. As part of this review the research team visited four prisons, including one female prison. The research team have produced a paper on early findings, and have conducted a review of the 15 most recent HMIP reports to ascertain the Inspectorate's findings on ACCT. Their report can be found here. **here**.

The Panel will consider this work alongside the outcome of an internal NOMS review on the use of ACCT with young people and PPO learning bulletins on this topic to determine the scope of the project in future.

Cross Sector learning

(Led by Deborah Coles)

The Panel recognises the importance of organisations learning from deaths in custody (including learning that is relevant across sectors). One of the key obstacles to timely learning is delays to inquests into deaths in custody. The Panel made a series of recommendations following an analysis of these delays in its paper to the Ministerial Board in October 2011.

The IAP has been working with the Chief Coroner's office to progress these recommendations. The Chief Coroner attended the IAP meeting on 9 December and gave an update on the Panel recommendations for the Coroners' office. He stated that he:

- Had undertaken a number of actions to improve delays in the system as well as the timing and quality of reports. These included identifying the worst/ slowest areas and holding meetings with them to address the delays, and holding training days and seminars with Coroners.
- He was also in the process of issuing guidance on pre-inquest hearings, which emphasized the importance of communication with victims' families.
- Regarding the database of all death in custody Rule 43 reports, reports would be uploaded onto the website alongside the responses. He was planning to have a regular review of responses with their reports every six months.

- He would be issuing guidance in the near future for mental health trusts on how they should undertake investigations following the death of a detained patient.

The Panel will be following up with the Chief Coroner's office to understand the impact of this activity and to take stock about its priorities for learning in future.

Article 2-Compliant Investigations

(Led by Professor Philip Leach)

The Panel has raised concerns that independent investigations are not being commissioned into deaths of detained patients. They worked with the Care Quality Commission (CQC) to obtain access to a small sample of serious untoward incident reports completed by NHS Trusts following deaths of detained patients, and produced an analysis of these in a paper to the

Ministerial Board in June 2013. The Panel highlighted the variation in quality and scope of the investigations and recommended that NHS England should produce guidance for mental health trusts on how they should undertake investigations which should include guidance on how to ensure investigations are Article 2 –compliant, where relevant. This recommendation was accepted and the Panel continues to liaise with NHS England on the production of updated guidance.

Deaths of Patients Detained under the Mental Health Act (MHA)

(previously led by Simon Armson)

The Panel has continued efforts to encourage the Care Quality Commission to work with the Health and Social Care Information Centre (HSCIC) to access data from the Mental Health Minimum Data Set in order to look further into the apparently high number of deaths due to pulmonary embolism and myocardial infarction. CQC has gained access to the relevant data and is currently considering timescales for completion of the work. We have had productive meetings with CQC about how they are developing their role in relation to deaths of detained patients.

In order to progress the Panel's work on the role of mental illness in deaths in custody, they have commissioned University of Greenwich to undertake a literature review. We expect to publish the review later in the summer and will be using the outcome of that piece of work and the range of activity happening at HMIC, Department of Health and the Home Office in relation to mental health and policing.

Family Liaison Work

(led by Deborah Coles)

Implementation and monitoring use of common principles

Since publication of the family liaison common standards and principles by the IAP in February 2013, the MOJ have launched a new guide for bereaved families, 'Guide to Coroner Services' which explains simply to bereaved people how the inquest process works, what they should expect to experience, what standards of service they should receive from those involved, how to find help and what to do if they were not satisfied by the service. The guide can be found **here**.

Later this year, the Panel plans to review the contents of the common standards and principles as well as their impact on organisational practices. The document can be found **here**.

Statistical analysis of deaths 2000-2012

The third IAP statistical report into deaths in custody, covering the period 2000-2012, has been published.

The report shows a breakdown of all recorded deaths of patients detained under the Mental Health Act and in Prisons and Young Offender Institutions (YOIs); Police; Prisons; Immigration Removal Centres (IRCs); Approved Premises (APs); Secure Children's Homes (SCHs); Secure Training Centres (STCs).

Some of the headline figures from the report are:

- In total there were 7,122 deaths recorded for the 13 years from 2000 to 2012. This is an average of 548 deaths per year. Of these deaths, 72% were men (5,123) and 28% (1,999) were women.

- There were 549 recorded deaths in state custody in 2012 compared to 515 in 2011.

- The majority (92.4%) of the 7,122 deaths in the last 13 years where of those detained under the Mental Health Act or in prison settings.

The full report can be found **here**.

The Harris Review

In February 2014 Lord Toby Harris was invited to lead an independent review into self-inflicted deaths in NOMS custody of 18-24 year olds. The purpose of the review is to make recommendations to reduce the risk of self-inflicted deaths in NOMS custody in the future, and will report to the Prisons Minister, in Spring 2015. Lord Harris is being supported by members of the Independent Advisory Panel on Deaths in Custody (IAP).

The Review is examining the self-inflicted deaths of 18-24 year olds since the roll out of the ACCT document – the care planning system for prisoners identified as at risk of suicide or self-harm. ACCT roll out was completed on 1st April 2007.

The Harris Review will focus on issues including vulnerability, effective communication and information sharing, safety, staff prisoner relationships, family contact and staff education and training. The Review will explore these issues through examining cases, existing and commissioned research, visiting prisons and Young Offender Institutions, holding hearings with stakeholders and people affected and interested more broadly, and a call for submissions.

Call for Submissions

On 1st May, the Harris Review issued a public Call for Submissions, which closed on Friday 18th July. The review is seeking to engage with key groups, and welcomed responses to the Call for Submissions via the Harris Review page on the IAP website. Views and comments are welcome at any time at **HarrisReview@justice.gsi.gov.uk**.

The Review has been meeting with key stakeholders to hear oral evidence relating to the issues being examined as part of the Review. So far these hearings, which have included stakeholders such as the Prisons and Probation Ombudsman, NOMS, the Independent Monitoring Board, NHS England and the Chief Inspector of Prisons, have been highly productive. Over the coming weeks and months, the review will continue to meet with government and non-government stakeholders, including for example, The Samaritans, the Prison Reform Trust and the CQC.

Secretariat update

Matt Leng left the Secretariat in August 2013. His replacement, Kishwar Hyde, was appointed to the role of Deputy Head of the Secretariat in October 2013. In addition, Laura McCaughan returned in April 2014 from maternity to resume her role as Head of Secretariat. Alice Balaquidan remains in her post as Secretariat support.

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**.

News

Police use of taser statistics for England and Wales, 2009 to 2011 publication

In September 2013, the Home Office announced the publication of statistics on Police use of Taser in England and Wales between 1 January 2010 and 31 December 2011.
https://www.gov.uk/government/publications/police-use-of-taser-statistics-england-and-wales-2009-to-2011/police-use-of-taser-statistics-england-and-wales-2009-to-2011

IAP Meeting 10 September 2013

The nineteenth meeting of the IAP took place in September 2013. The Panel received updates about IAP projects in relation to the physical restraint common principles, the serious untoward incident (SUI) reports, learning from near deaths, the summary of Rule 43 recommendations, the quarterly deaths in custody data, and the preparation for the Ministerial Board in October 2013.
http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-10-september-2013/

IAP Meeting 9 December 2013

The twentieth meeting of the IAP took place in December 2013. The Panel received updates from the Consortium on the progress of their research and indication of when their reports and findings were due. His Honour Judge Peter Thornton QS also attended and provided an update on his work since his appointment in September 2012 with an update in relation to a number of recommendations attached to his office.
http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-9-december-2013/

IAP Meeting 10 March 2014

The twenty-first meeting of the IAP took place in March 2014. The Panel received updates from the consortium on the progress of their reports. Dame Anne Owers also attended to give an overview of the IPCC Review due to be published.
http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-10-march-2014/

PPO annual report for 2012/13

The Prisons and Probation Ombudsman (PPO) published their annual report for 2012/13. During this period they opened 192 investigations into deaths. Of these, 118 are investigations into natural cause deaths and 55 on apparently self-inflicted deaths.
http://www.ppo.gov.uk/annual-reports.html

Inquest into the death of Jimmy Kelenda Mubenga

The inquest into the death of Jimmy Kelenda Mubenga took place between 13th May 2013 and 9th July 2013. The coroner published her report and made six recommendations. The Independent Advisory Panel (IAP) will continue to follow progress on the recommendations.
http://iapdeathsincustody.independent.gov.uk/news/inquest-into-the-death-of-jimmy-kelenda-mubenga/

Information sharing and suicide prevention: consensus statement

In January 2014, the Department of Health in England and eight professional organisations published a consensus statement on information sharing and suicide prevention.
https://www.gov.uk/government/publications/suicide-prevention-report

Youth Justice Statistics 2012/13 England and Wales

The Ministry of Justice and the Youth Justice Board published the Youth Justice Statistics 2012/13 for England and Wales. The report contains a section on deaths in custody and serious incidents.
https://www.gov.uk/government/publications/youth-justice-statistics

Care Quality Commission (CQC) Mental Health Act Annual Report 2012/13

The Care Quality Commission (CQC) published their annual report on its role in monitoring the use of the Mental Health Act. The report is based on findings from visits made by CQC's Mental Health Act Commissioners to mental health patients. Chapter 5 covers access to care during a mental health crisis and the Mental Health Act. Chapter 6 covers restraints and deaths of detained patients.
http://www.cqc.org.uk/content/mental-health-act-annual-report-201213

Independent review into self-inflicted deaths of 18-24 years olds in custody

In February 2014, the Ministry of Justice announced that it would be establishing an independent review into the self inflicted deaths of 18-24 year olds in custody. The purpose of the review will be to make recommendations for reducing the risk of future deaths in custody focusing on 18-24 year olds but it will also identify learning that will benefit all age groups.
http://www.justice.gov.uk/about/deaths-in-custody-independent-review

Call for Submissions for the Harris Review

The Harris Review, an independent review into self-inflicted deaths of 18-24 year olds in custody, issued a call for submission. The review led by Lord Toby Harris, chair of the Independent Advisory Panel on Deaths in Custody (IAP), with the support of IAP members, will be making recommendations to reduce the risk of future self-inflicted deaths in custody.
http://iapdeathsincustody.independent.gov.uk/news/the-harris-review-issues-its-call-for-submissions/
Also see feature on **page 8**.

Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis

The Department of Health and Home Office published their joint statement which sets out the principles and good practice that should be followed by health staff, police officers and approved mental health professionals when working together to help people in a mental health crisis.
https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

New guide for Bereaved Families

The Ministry of Justice launched a guide for people who have to become involved with inquests. The new 'Guide to Coroner Services' explains to bereaved people how the inquest process works, what they should expect to experience, what standards of service they should receive from those involved, how to find help and what to do if they were not satisfied by the service.
https://www.gov.uk/government/news/bereaved-families-at-the-heart-of-the-coroner-system

Draft guidance on police post-incident management - consultation

The Independent Police Complaints Commission launched a consultation in February on police post-incident management.
http://www.ipcc.gov.uk/page/consultations

Fourth annual report of the UK's NPM 2012/13 published

In March 2014, the HM Inspectorate of Prisons published their fourth annual report of the UK's National Preventative Mechanism (NPM) for 2012-13. The NPM is made up of 20 independent bodies and co-ordinated by HM Inspectorate of Prisons. It was established following the UK's ratification of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).
http://www.justiceinspectorates.gov.uk/hmiprisons/media/press-releases/2014/03/national-preventive-mechanism-publishes-annual-report-into-uk-detention/

IAP mid term report 2014

The IAP published their mid term report, which provides an overview of the key achievements made by the IAP since April 2012.
http://iapdeathsincustody.independent.gov.uk/news/iap-mid-term-report-2014/

Appointment of five new Members of the Independent Advisory Panel on Deaths in Custody

The Ministry of Justice, in consultation with Home Office and Department of Health, made five new appointments to the Independent Advisory Panel on Deaths in Custody.
http://iapdeathsincustody.independent.gov.uk/news/appointment-of-five-new-members-of-the-independent-advisory-panel-on-deaths-in-custody/

Review of the IPPC's work in investigating deaths report publish

In April, the IPCC published the result of their review into their independent investigation of deaths following contact with the police. This followed criticism and concerns about the approach, timeliness and thoroughness of some of their investigations, particularly those deaths following the use of restraint or force.
http://www.ipcc.gov.uk/page/review-ipccs-work-relation-cases-involving-death

NOMS response to the independent investigation into an incident at HMP Pentonville on 24 August 2010

The National Offender Management Service (NOMS) response to the independent investigation into the circumstances surrounding the incident at HMP Pentonville on 24 August 2010 that led to Mr Atlantic sustaining serious injuries has been published.
http://iapdeathsincustody.independent.gov.uk/news/independent-investigation-into-the-incident-at-hmp-pentonville-on-24-august-2010/

Coroners' statistics 2013 England and Wales

The Ministry of Justice has published the Coroners Statistics 2013 for England and Wales. Annual National Statistics on deaths reported to coroners, including inquests and post-mortems held, inquest conclusions recorded and finds reported to coroners

under treasure legislation.
https://www.gov.uk/government/publications/coroners-statistics-2013

IAP Death in Custody Parliamentary Log

In June, the Independent Advisory Panel (IAP) on Deaths in Custody Parliamentary Log which provides a summary of all Parliamentary business concerning deaths in state custody since 1 April 2009 was updated. 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/

Detention and custody consultation launched by the College of Policing

The College of Policing has launched a consultation in relation to their review of existing Authorised Professional Practice (APP) in all aspects of detention and custody. The consultation starts from 24 June until 12 August 2014.
http://www.app.college.police.uk/consultation/detention-and-custody-consultation/

Next Issue

The next e-bulletin will be published in October 2014.

The Independent Advisory Panel

Panel Chair

Lord Toby Harris
Lord Harris has been Chair of the IAP since it was established in 2009. He was made a Life Peer in June 1998 and is Chair of the Labour Peers.

He is a former Chair of the Metropolitan Police Authority and the Association of London Government. In Parliament, he Chairs the All-Party Parliamentary Group on Policing, was a member of the Joint Committee on National Security and in 2013 he chaired the House of Lords Committee on the Olympic and Paralympic Legacy. He has been Chair of the National Trading Standards Board since 2013.

Panel Members

Professor Philip Leach
Philip Leach is Professor of Human Rights Law at Middlesex University, a solicitor, and Director of the European Human Rights Advocacy Centre. He has extensive experience of representing applicants before the European Court of Human Rights. He is on the Editorial Board of European Human Rights Law Review, a Trustee of the Media Legal Defence Initiative and a member of the Legal Advisory Board of the Human Dignity Trust.

He has been a member of the Independent Advisory Panel on Deaths in Custody since 2009, leading on its work relating to Article 2-compliant investigations.

Deborah Coles
Deborah Coles is co-director of INQUEST, a charity providing expertise on contentious deaths and their

investigation with a particular focus on custodial deaths. She leads its policy, legal and strategic work and is called upon as an expert to numerous committees and inquiries including the IPCC Review on investigation of Article 2 deaths. She has expertise in specialist areas including coronial reform, policing, human rights compliant investigations, family engagement, traumatic bereavement, juvenile and youth justice, race and gender and criminal justice.

Deborah has been a member of the Independent Advisory Panel since 2009, leading its work stream on cross sector learning, equalities and family liaison.

Professor Richard Shepherd

Professor Richard Shepherd is Consultant Forensic Pathologist at the Royal Liverpool Hospital and a leading forensic pathologist in the field of deaths during restraint, with experience of deaths in all forms of custody, including those from natural, suicidal and homicidal causes. He has sat as an expert on the Restraint Advisory Board Panel for the Children's Secure Estate (MMPR) and the UKBA panel for Non Compliance Management.

Richard has been a member of the Independent Advisory Panel on Deaths in Custody since 2009 and leads the IAP workstream on the use of physical restraint.

Stephen Cragg QC

Stephen Cragg is a barrister specialising in public law, and human rights. His main areas of public law include police law, community care and health law, the retention and disclosure of information by public bodies, the criminal justice system, and coroners' inquests. He has acted in many death in custody inquests on behalf of families of the deceased.

Stephen sits as a part-time judge for the mental health review tribunal.

Matilda MacAttram

Matilda MacAttram is founder and director of Black Mental Health UK (BMH UK), a human rights campaigns group established in 2006 to raise awareness and address the stigma associated with mental illness in the UK's African Caribbean communities. She is a member of the Government's Ministerial Working Group on Mental Health and Equalities, as well as the Care Quality Commissions' Annual Mental Health Act Report Expert Advisory Group, and New Scotland Yard's Vulnerability Independent Advisory Group. Matilda is also a fellow of the United Nations, Office of the High Commissioner for Human Rights and the Working Group of Experts on People of African Descent.

Also a journalist and public speaker, she is frequently asked to comment in print and broadcast media on issues arising from BMH UK's work.

Dinesh Maganty

Dinesh Maganty is currently Lead Consultant for intensive care for Birmingham and Solihull Mental Health NHS Foundation Trust Secure Care Services. He is a member of the National Clinical reference group for Health and Justice for NHS England. He has acted as a Psychiatric expert instructed by coroners in cases of death in prisons and psychiatric hospitals for the last decade.

Dinesh has also acted as an expert for the NHS litigation authority in cases of deaths in hospitals and in the community and has been an expert in over 700 criminal and civil cases.

Meng Aw-Yong

Dr Meng Aw-Yong is a practising Forensic Medical Examiner and Medical Director for the Met Police and is currently working in Emergency Medicine at Hillingdon Hospital. Meng is also a Medical Member Social Entitlement Chamber, and a council member of the British Academy of Forensic Science.

He is an expert witness at inquests. He is a former council member of College of Emergency Medicine and President of Clinical Forensic and Legal Medicine for the Royal Society of Medicine.

Graham Towl

Professor Graham Towl is Pro Vice Chancellor and Deputy Warden at Durham University. He is a Professor of forensic psychology and was formerly Chief Psychologist at the Ministry of Justice. He has extensive experience working in criminal justice and mental health and is widely published.

Previously he chaired the Prison Service Suicide Awareness Support Unit research partners group. He is a Council Member of the Health and Care Professions Council and the national mental health advisor to the student helpline, Nightline.