INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

Welcome to the seventh 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 November 2011.

In January 2012, following an evaluation of its effectiveness, the Ministerial Council on Deaths in Custody, of which the IAP forms one tier, was granted a further three year term by Ministers. Individual Panel members have been reappointed for terms of either two or three years to ensure we have continuity to complete important pieces of work. The Panel is committed to continuing its focus on developing safer practices to prevent deaths in custody and to ensuring learning is shared across sectors.

The Panel met on 31 January to review the achievements we made in our first term, considered areas in which we had not achieved our objectives and discussed wider issues such as our role, purpose and relationship with stakeholders. We also discussed our strategic priorities for the next term, and an initial work plan has been devised which was consulted on at our second national stakeholder day on 2 March 2012. Attendees, through a series of facilitated workshops, had the opportunity to discuss our future priorities and were able to suggest potential further work. Over the next few months, the IAP will be incorporating the discussions from the day into our future work.

Attendees had the opportunity to hear from Crispin Blunt MP, Parliamentary Under-Secretary of State at the Ministry of Justice who delivered the keynote speech and Andre Rebello, Honorary Secretary of the Coroners Society of England and Wales. The event provided a valuable forum for the Panel to focus on the next stages of its work and for the sharing of learning and best practice between agencies and organisations. We all found the day to be of incredible value.

More generally, this e-bulletin also provides an update on the ninth Ministerial Board on Deaths in Custody; progress of the six IAP workstreams; an invitation to join our Practitioner and Stakeholder Group and information about the IAP's Learning Library.

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

Thank you,

Toby Harris

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Ministerial Board on Deaths in Custody

The ninth meeting of Ministerial Board on Deaths in Custody was held on Tuesday 7 February 2012 and was chaired by the Minister of State for Care Services at the Department of Health, Paul Burstow MP. Lord Harris presented a report from the IAP's second family listening day for families affected by the death of a relative detained under the Mental Health Act; provided an update on Mendas' research into learning from Rule 43 reports and presented emerging findings from Her Majesty's Inspectorate of Prisons (HMIP) and HMI Constabulary's research into Person Escort Record (PER) forms. The Panel's work on Article 2 investigations of deaths in Secure Children's Homes (SCHs) and the Panel's strategic planning meeting were also discussed.

The National Offender Management Service (NOMS) presented emerging findings from their analysis of unclassified prisoner deaths in 2010; the Association of Chief Police Officers' (ACPO) and Department of Health's work on Section 136 of the Mental Health Act (MHA) was also discussed and an update from the Ministry of Justice on the Government's plans to implement the role of Chief Coroner was provided. NOMS' updated the Board on the implementation of their revised Cell Sharing Risk Assessment. The Independent Police Complaints Commission (IPCC) discussed their review of work in relation to Article 2 of the European Convention on Human Rights and INQUEST raised the recent HMIP inspection of HMP Styal and deaths of young people in prison.

IAP publish end of term report

In February 2012, the IAP published its end of term report, which reflected on the main achievements of the Panel in its first term and identified a number of areas the Panel would like to focus on going forward. These include the development of existing projects, such as common principles on the use of restraint and monitoring implementation of the information sharing statement. The report also proposed new projects, including the development of last year's statistical analysis to understand whether vulnerable groups are over-represented in the numbers of deaths in custody.

The report is available to download here http://iapdeathsincustody.independent.gov.uk/news/iap-publish-their-end-of-term-report/

The IAP's second national stakeholder consultation event

On Friday 2 March 2012, the IAP held its second national stakeholder consultation event, which marked the end of the Panel's first term. The event was very well attended with a wide range of stakeholders from the police, prison service, government departments and agencies, inspectorates and investigative bodies, third sector organisations and legal and medical experts.

The aim of the day was to enable stakeholders to contribute ideas and to help prioritise the Panel's work programme for the next term. The workshop sessions were facilitated by Panel members and the specific contents of the discussions have not been attributed to individuals. Attendees were encouraged to be open, to report good practice and to identify areas of concern. Each workshop was delivered twice to enable all attendees to participate in a range of topics.

Mental health and deaths of detainees across the custodial sectors – including places of safety under section 136 of the Mental Health Act (MHA)

The objective of this workshop, led by Simon Armson, was to explore the problems of delivering health based places of safety for individuals detained under section 136 of the MHA and enable stakeholders to contribute their knowledge and experience of the risks of self-inflicted and other deaths for detainees with mental illness in all custodial sectors.

Key themes and issues from the workshop:

- All new police custodial staff should receive specific training on Section 136 issues, particularly around inappropriate use of these detentions. For example, using police stations in the first instance as a place of safety.
- Despite Section 136 detentions involving numerous agencies, there was a lack of central ownership of a policy or commissioning which prevented effective multi-agency working. It was important that these issues had strategic leadership and support to provide assurances to practitioners.
- There are pockets of good multi agency partnerships at a local level, but nothing on a national basis. This means that good practice will be difficult to replicate. Potential role for Health and Well-Being Boards to ensure any concerns with Section 136 are addressed and disseminate best practice and learning.
- Lack of accurate data on Section 136 detentions. More accurate data could help inform an evidence base to develop future strategies for this form of detention. A statutory, mandated form on Section 136 detentions to be filled in by agencies may help enable national benchmarking.
- If deaths of detained patients in secure hospitals were subject to the same independent investigatory processes as other agencies, it would help provide more effective learning on particular successes and failures of Section 136 detentions, which would help inform future strategies.

Restraint related deaths – common principles on use of restraint

The objective of this workshop, led by Professor Richard Shepherd, was to seek feedback on the IAP's draft common principles. The aim of these principles is to provide, at a minimum, a set of criteria for sectors to implement when setting policy and designing practices for safer restraint. Stakeholders also discussed how such principles could be implemented by services and how to evaluate their effectiveness.

Key themes and issues from these workshops were:

- Important for those who apply restraint in custody to not only have first aid training, but also have a basic knowledge of resuscitation techniques, given the potential dangers of the restraint procedure manifesting into a medical emergency.

- Restraint training packages should be reinforced and refreshed regularly to ensure the learning is relevant. There was uncertainty about what restraint training was available to temporary agency (contracted) staff.
- There are difficulties in determining how long a restraint procedure should be applied. However, allocating a timeframe for each technique may mean that techniques are used for inappropriate periods of time.
- Important to ensure that the principles highlight the importance of de-briefing following restraint. These should involve not only the individual who has applied restraint, but also the restrained person.
- Lack of clear lines of accountability between agencies during restraint can cause confusion. For example, when the police are called to restraint a patient in a hospital.

Information sharing statement – implementation and evaluation

The objective of this workshop, led by Professor Stephen Shute, was to discuss the Panel's information-sharing statement, which has been designed for practitioners in all custodial settings to communicate the importance of sharing information about detainees to manage risks of self harm and suicide. Stakeholders were asked how the statement might be best communicated to front line staff.

Key themes and issues from these workshops were:

- There was recognition that the Data Protection Act was not a block to effective information sharing, as it allows the fair and lawful sharing of information.
- It is critical to secure service leaders' endorsement of the statement to provide assurances to practitioners responsible for sharing information.
- The statement should highlight that information sharing should not be excessive. Only relevant (and specific) information should be shared to allow custodial staff to effectively manage the individual's risk of self-harm / suicide.
- It was important to identify whether the statement was having an impact on improving information sharing practices. The inspectorates and investigative bodies could have a role to play here.

Investigations into deaths in custody – learning lessons to prevent future deaths, family involvement & equalitiy issues in deaths in custody

The objective of this workshop, led by Deborah Coles and Professor Philip Leach, was to explore how custodial sectors learn from investigations into deaths in custody to prevent future deaths (including from Rule 43 reports) and how those conducting investigations involve families in setting terms of reference and sharing any findings. Equalities issues raised by deaths in custody were also discussed.

Key themes and issues from these workshops were:

- Recommendations for change and learning from deaths has to be sustainable in order to make a difference in the long term. Staff need examples of good practice to help them prevent self-inflicted deaths.

- Investigations and inquests into deaths in custody are variable in terms of timeliness, quality and the value of the learning. A more consistent approach is required.
- Importance of early contact with families after a death in custody and for the specialist role of family liaison officer to explain the end to end process to families – including the number, type and timescale of investigations.
- Staff support after deaths is very important – they need ongoing support and a recognition that deaths can impact on their own mental health and ability to cope with stress at work. Improvements would enable staff to contribute more effectively at inquests and learn from significant events.

Discussions from the day helped the Panel to refine its proposed future work plan, which will be signed off by the co-sponsors of the Ministerial Council in April 2012. The Panel's response to stakeholder's suggestions for further work will be published on the website in due course. Whilst the Panel will continue to lead distinct workstreams for particular areas of work, they will seek to work together on some of the issues cutting across their areas of expertise.

Update on the IAP Workstreams

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

Cross Sector Learning

The Panel commissioned research from Mendas to understand the impact of Rule 43 reports on the custodial sectors' organisational learning. To date, they have conducted 20 interviews with coroners and experts in the custodial sectors and regulatory bodies. Mendas also constructed a database of all known death in custody cases in which Rule 43 letters following a death have been issued, which has enabled them to analyse the learning points raised by coroners.

The researchers have also selected a sample of cases to examine in more detail. This will enable them to draw conclusions about the extent to which the sectors are learning from Rule 43 letters and to make suggestions for improvement in terms of processes, governance and cultural approaches to learning. The Panel will receive the results of the research in May and will present it with recommendations at the next Ministerial Board in June 2012.

Deaths of Patients Detained under the Mental Health Act (MHA) and Section 136 of the MHA

In November 2011, the Panel chaired a roundtable bringing together ACPO, the Care Quality Commission (CQC), HMIC, IPCC, Metropolitan Police Service, Offender Health and the Royal College of Psychiatrists. The aim of this was to identify the local arrangements in place for the provision of Section 136 detainees and to discuss potential costs of staffing additional places of safety (in the context of ongoing budget cuts). There was a consensus from attendees that police custody was not the best place to detain a person under Section 136. Both CQC and IPCC thought accuracy of the data on Section 136 detentions could be improved, especially to capture the outcome following initial contact with the police. ACPO and IPCC had agreed to discuss how this could be included in the annual custody data returns. The Panel will monitor the outcome of these actions.

However, there was a lack of evidence about how extra resources had been used by trusts to create places of safety in health settings, and there were anecdotal accounts that new provision was under-used due to pressure on staff resources.

The Panel have worked with ACPO and DH to identify how the extra resources have been disbursed and to ascertain the level of compliance with the DH / ACPO memorandum of understanding for the provision, management and conveyance to places of safety of those individuals detained under Section 136. ACPO and DH presented a joint paper to the Ministerial Board in February 2012, which included feedback from 37 police forces. This showed that the use of health based places of safety is increasing but there is a mixed picture – with some very effective police and health trust partnerships and low usage of police custody, compared to areas where police custody is used more frequently and partnerships are functioning less well. The report highlighted that some forces were also unable to secure adequate access to health based places of safety, primarily because of their unwillingness to accept intoxicated detainees.

The paper recommended that the future NHS Commissioning Board (NHSCB) should commission health based places of safety alongside offender health services. The IAP welcomes this recommendation and recognises the importance of clear commissioning responsibility for Section 136 places of safety. The Panel also heard from CQC about their current programme of MHA monitoring visits to Section 136 places of safety across London and more widely. CQC's intend to embed Section 136 monitoring in its ongoing cycle of visits. This is welcomed by the Panel and we will be adding our support to CQC to encourage Trusts and police to apply any learning points from the findings of these visits.

The Panel have also continued to pursue recommendations in relation to improving physical health of detained patients to reduce the number of natural cause deaths. The Panel met with Paul Jenkins, Chief Executive of Re-think Mental Illness, in December to discuss the IAP's recommendations. Re-think were keen to engage with the Panel and to consider how to incorporate their insights into the joint Third Sector guidance that had been commissioned to support delivery of the Department of Health strategy, 'No Health without Mental Health'.

Simon Armson and Professor Philip Leach will also be working together to scope research into independent investigations of deaths of detained patients. The Department of Health have been helping the Panel identify a route to Strategic Health Authorities to issue a short questionnaire to gauge the number of independent investigations commissioned. The Panel will take this forward in the next three months.

Article 2 Compliant Investigations

Professor Philip Leach's paper on Article 2-compliant investigations to the Ministerial Board in June 2011 recommended that the Prisons and Probation Ombudsman's (PPO) remit should be extended to cover investigations of deaths of children who are placed in Secure Children's Homes (SCHs) as the existing arrangements did not provide sufficient independence. A follow up meeting between IAP and the PPO, YJB, MoJ and Ofsted was held in August 2011 to discuss the proposals.
DfE and MoJ legal advisers have since considered

the Panel's recommendation, and DfE have indicated that are willing to consider the practical and financial implications of such arrangements to enable consistency across the secure youth estate. They did not agree that PPO investigations would be required to comply with Article 2. Their response was discussed at the Ministerial Board in February and DfE will be invited to a future meeting to agree how they are planning to develop this piece of work.

Use of Physical Restraint

In February 2012, the Panel held a roundtable meeting with UK Border Agency (UKBA), Department of Health, Institute of Psychiatry, NOMS, Youth Justice Board, Restraint Advisory Board and the Association of Chief Police Officers (ACPO) to discuss the Panel's common principles on the use of restraint. Attendees agreed that the principles were sensible and could be communicated to commissioners of custodial services to guide them when commissioning services to provide safe training and practice on restraint. The Panel will review the principles and approach service leaders to see how best these principles could be implemented.

The Panel has also, in conjunction with ACPO, begun to identify ways of improving police reporting mechanisms on the use of restraint. ACPO provided a sample of use of force data from one police force, which we will be analysing to estimate the prevalence of use of restraint (i.e. how many times restraint was used in a given period and compared to the number of detainees), with a view to informing a justification for recommending that police forces should submit use of force data for analysis by a suitable body. The Panel believes it is crucial to evidence how many times use of force occurs in order to gain an understanding of the situations that lead to restraint, to identify any safety issues, and to highlight good practice to share across the sectors.

Information Flow through the Criminal Justice System

On behalf of the Panel, Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Constabulary (HMIC) analysed a sample of PER forms completed by police. They inspected 181 PER forms from five forces to examine the extent to which information about the risk of self-harm obtained during detention in police custody was accurately recorded and likely to be useful in subsequent care planning as the detainee moved along the criminal justice system.

This is a small sample, as 1 million PERs are completed each year. Nevertheless, they found that forms were not fully completed in 33 out of the 181 cases. Concerns were also highlighted about inconsistent or vague information and a lack of concordance between risk information on the PER and that on police custody records. The Inspectorates encountered problems with following up how records were dealt with in prisons (in part due to limited access to P-Nomis).

The Inspectorates have agreed to conduct further fieldwork in a number of prisons and young offender institutes (YOIs) to explore the extent to which information contained in PERs is helpful to staff in prisons and YOIs when assessing risk of self-harm and devising care plans. They will present emerging findings to the Ministerial Board in June 2012 with a final report being made available in October 2012.

In March 2012, Professor Shute met with the General Medical Council (GMC) to discuss the information sharing statement. The GMC were supportive of the work being done by the Panel in this area and have suggested some minor changes to maximise its impact. The Panel will discuss these proposed changes with the Information Commissioner and once agreed, will approach service leaders for their thoughts on how best to communicate this to practitioners. The Panel will then monitor and evaluate its effectiveness on improving information sharing practices through its next term.

Joining the Practitioner and Stakeholder Group

There are now over 100 members of the Practitioner and Stakeholder Group, drawn from inspectorate and investigative bodies, lawyers, Third Sector organisations, academics and practitioners from the custodial sectors. If you would like to join this group, please contact Alice Balaquidan on the email address below. The Panel would like to encourage families to join the group in order to hear their views on whether the focus of our work is effective in meeting families' needs. Members of the group receive regular email updates on the work of the Panel and are invited to comment on the development of its workstreams. If you would like to become a member of this group, please email Alice at alicia.balaquidan@noms.gsi.gov.uk and an invite letter will be sent to you.

IAP Learning Library

The Secretariat acts as a central 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, which may have cross sector applicability. We are committed to developing this tool. 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

PPO on natural cause deaths 2007-10

The Prison and Probation Ombudsman (PPO) has published their latest report on learning from PPO Investigations into natural cause deaths in prison custody. http://www.ppo.gov.uk/docs/learning_from_ppo_investigations-natural_cause_deaths_in_prison_custody.pdf

Re-appointment of the IAP Members

On 21 February Crispin Blunt, Parliamentary Under-Secretary of State for the Ministry of Justice, announced by Written Ministerial Statement that the Ministerial Council on Deaths in Custody will continue for a further three year term. The Chair of the IAP has been reappointed, as have Panel members for terms of two and three years. http://iapdeathsincustody.independent.gov.uk/news/re-appointment-of-the-iap-members/

IAP published their end of term report
The IAP published their end of term report which marks the end of the Panel's first term. It details the Panel's key achievements since the mid term report was published in March 2011 and sets out future priorities for the Panel in its second term. http://iapdeathsincustody.independent.gov.uk/news/iap-publish-their-end-of-term-report/

New Chair of the IPCC appointed
In February the Home Secretary, Theresa May, announced the appointment of Dame Anne Owers as the new Chair of the Independent Police Complaints Commission (IPCC). Dame Anne was appointed by Royal Warrant for five years. She is the second permanent Chair of the Commission since it was established. http://www.ipcc.gov.uk/news/Pages/160212_owers.aspx

IAP published their second family listening day report
The IAP published a report on its second family listening day held in September 2011. It focused on bereaved families whose relatives died whilst detained under the Mental Health Act. The report brought together key themes from the day including family suggestions for improvements to the system. http://iapdeathsincustody.independent.gov.uk/news/iap-publishes-the-report-on-its-second-family-listening-day/

Decision in the case of Rabone v Pennine Care Trust
In November 2011 the Supreme Court heard the case of Rabone v Pennine Care NHS Trust and handed down a judgment on 8 February 2012. It states that the operational obligation under Article 2 of the Convention, which is a positive duty to take preventative operational measures to safeguard an individual's life in certain circumstances, is owed to voluntary mentally ill hospital patients as well as those detained under the Mental Health Act 1983. http://iapdeathsincustody.independent.gov.uk/news/supreme-court-decision-in-the-case-of-rabone-v-pennine-care-nhs-trust/

Independent investigation into the case of 'JL' published
The National Offender Management Service (NOMS) response to the independent investigation conducted by Selena Lynch into the life-threatening self-harm of JL at HM Young Offenders Institute (YOI) Feltham on 19 August 2002 has been published. http://iapdeathsincustody.independent.gov.uk/news/independent-investigation-into-the-case-of-jl-published/

Death in prison custody 2011 published
The Ministry of Justice (MoJ) has announced that there were 57 apparent self-inflicted deaths among prisoners in England and Wales during 2011. http://www.justice.gov.uk/news/press-releases/moj/newsrelease010112

CQC's Mental Health Act Annual Report 2010/11
The Care Quality Commission (CQC) published their second annual report on its role in monitoring the use of the Mental Health Act from 1 April 2010 to 31 March 2011.

The report is based on findings from visits made by CQC's Mental Health Act Commissioners to mental health services and patients, as well as the work of their Second Opinion Appointed Doctors. http://www.cqc.org.uk/public/reports-surveys-and-reviews/reports/mental-health-act-annual-report-2010/11?1

IAP Meeting 7 December 2011

The twelfth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place on the 7 December 2011. At this meeting, the IAP discussed planning for the next IAP Stakeholder Consultation Event on 2 March 2012, the Government's plans to implement the role of the Chief Coroner, preparations for the ninth meeting of the Ministerial Board in Deaths in Custody on 7 February 2012, progress on the IAP workstreams and strategic planning for the proposed second term of the Panel. http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-7december-2011/

Learning the Lessons Committee publish latest bulletin

The Learning the Lessons Committee has produced its latest bulletin on lessons drawn from reports and information on investigations which the Committee receives from the Independent Police Complaints Commission (IPCC) on a regular basis. http://www.learningthelessons.org.uk/Pages/Bulletin15.aspx

Next Issue

The next e-bulletin will be published in July 2012.