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INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

Welcome to the eighth 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 2012.

The Secretariat has begun to update the Panel's statistical analysis of all recorded deaths in state custody. In order to develop the level of analysis contained in the report, the Care Quality Commission (CQC) has agreed to undertake an in-depth examination of the data to provide us with more confidence about trends and learning from the data which could be shared across all organisations. The Panel will use their analysis to produce a more detailed publication in October 2012. I would like to thank the CQC for their support with this piece of work.

I recently had a productive meeting with His Honour Judge Peter Thornton QC, the newly appointed Chief Coroner. The Panel have long held the view that the office of Chief Coroner is crucial to provide oversight for coroners and in particular, the Panel hope that the appointment will have an impact on reducing delays to death in custody inquests, which can have an enormous emotional impact on the families and also frustrate the timely sharing of learning to try and prevent future deaths. The Panel look forward to working with the Chief Coroner on this priority area.

This e-bulletin also provides an update on the tenth Ministerial Board on Deaths in Custody; progress of the six IAP projects; 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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Update on the IAP's statistical analysis of all recorded deaths in state custody

In October 2011, the IAP published its first statistical analysis of all recorded deaths in state custody between 1 January 2000 and 31 December 2010. In the report, the Panel made a commitment to develop its level of analysis to make evaluative conclusions about the data.

On behalf of the Panel, CQC have agreed to analyse deaths in custody data recorded between the 1 January 2000 and the 31 December 2011. The analysis will seek to draw out relevant trends and determine any key learning points for the Panel to disseminate to the custodial sectors. Specific areas of analysis the Panel are interested in are:

- Equality issues, in particular, the IAP would like the analysis to identify from the available data, any dis-proportionality of deaths in all custodial settings by type of death (e.g. self inflicted/restraint related) and protected characteristics (where the data allows – that is, race, age and gender).
- Natural cause deaths and the apparent increase in natural cause deaths in some sectors.

The analysis will be published on the IAP website in October 2012.

Ministerial Board on Deaths in Custody

The tenth meeting of Ministerial Board on Deaths in Custody was held on Tuesday 12 June 2012 and was chaired by the Parliamentary Under-secretary of State at the Ministry of Justice, Crispin Blunt. Lord Harris provided an update on the progress with implementing the IAP recommendations made to the Ministerial Board since March 2010; ongoing research into learning from Rule 43 reports and plans for a meeting with a range of organisations to discuss the applicability of the IAP's common principles the use of restraint in mental health settings. Officials from the Department for Education (DfE) also attended the Board to confirm how they would be implementing the Panel's recommendation that the PPO should investigate deaths of children in Secure Children's Homes.

The findings from the National Offender Management Service (NOMS) review of unclassified prisoner deaths in 2010 and 2011 was also presented to the Board; Her Majesty's Chief Inspector of Prisons updated members about their inspection of PER forms and INQUEST discussed independent investigations of deaths of detained patients.

Chair of IAP meets with the new Chief Coroner

Lord Harris met with Judge Peter Thornton QC on 13 July. He has been appointed as the first Chief Coroner and will take up office in September. Lord Harris discussed key Panel projects relevant to the Chief Coroner's remit including learning from Rule 43 reports, delays to death in custody inquests and family liaison during an inquest. There was also a discussion about the importance of transferring cases out of jurisdiction

to address delays to death in custody inquests and attempts to simplify funding arrangements and future training for coroners. The Chief Coroner will also be joining the Ministerial Board on Deaths in Custody and the Panel look forward to working with him in the future.

Update on IAP Projects

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

Cross Sector Learning

The research commissioned by the Panel into the impact of Rule 43 letters on organisational learning to prevent future deaths in custody has been completed and the Panel has received a draft report. The Secretariat is working with the researchers to refine their findings in order for them to be presented to the Ministerial Board on 9 October, alongside Panel recommendations for improvement.

Family liaison

At its second consultation day in March 2012 the Panel held a workshop on family liaison following investigations of deaths in custody. This confirmed that many services have developed good practice in working with families, although there are inconsistencies between organisations about the extent to which families are provided with information flowing from investigations. Attendees agreed that good practice should be shared between organisations to help them develop the services offered to families.

Deborah Coles has since developed a draft set of standards and has sought feedback from custodial organisations, the Department of Health and investigative bodies. The standards are intended as high level principles to guide the design and delivery of family liaison following a death in custody. Many organisations have already incorporated some, if not all, of these. The Panel has updated the draft following feedback and will be sharing the standards with the stakeholder and practitioner group for further comment over the summer.

Mental health – deaths of those detained under the Mental Health Act (MHA) including Section 136.

Simon Armson attended a conference in July on improving physical health for people with mental health conditions to support his work in taking forward the Panel's recommendations about natural cause deaths of detained patients. The Panel also met with CQC and the Health and Social Care Information Centre in May to discuss the data on natural cause deaths. They have agreed to collaborate on a proposal for a re-analysis using a better comparator. The Panel is due to receive the proposal in September and will discuss it at their next meeting.

Simon Armson conducted a consultation with a range of stakeholders to help define a specification for a literature review as to how mental disorder amongst detainees relates to self-inflicted deaths and natural cause (albeit unexpected) deaths in all custodial settings. He received feedback from a range of organisations including ACPO, the Royal College of Psychiatrists, IPCC and members of the Bradley Group. The specification is now being refined to take account of feedback and further meetings with academic researchers are planned before commissioning the review.

[1] The Bradley Group brings together organisations to support and encourage implementation of the Bradley Report.

In May 2012, the Secretariat attended the Royal College of Psychiatrists (RCPsych) working group on Section 136 of the MHA. Representatives from the Association of Chief Police Officers (ACPO), Welsh Assembly Government, DH, Her Majesty's Inspectorate of Constabulary (HMIC), CQC, Metropolitan Police Service, Royal College of Nursing, Health and Social Care Information Centre and the College of Social Work were in attendance.

Attendees discussed data collection, in particular, issues about the lack of reliable data collection on the use of Section 136, issues relating to best practice and outcomes of Section 136 assessments. The importance of good local working relationships was also discussed and how this could improve the care pathway for detainees. There was concern with the use of police custody suites to hold Section 136 detainees. Attendees thought there was important roles for NHS commissioners in future to ensure use of health based places of safety.

The RCPsych working group is taking forward many of the issues raised at the IAP's Section 136 roundtable held in November 2011. The Panel will monitor the work of this group and consider the outcome of the joint HMIC and CQC thematic inspection of Section 136 before planning any further work in this area.

Article 2 Compliant Investigations

In June 2011, Professor Philip Leach presented a paper to the Ministerial Board on Article 2-compliant investigations, which included a recommendation that any future deaths in Secure Children's Homes (SCHs) should be investigated by the Prisons and Probation Ombudsman (PPO). The Panel held a number of positive meetings with DfE, PPO, Ministry of Justice, Youth Justice Board and Ofsted to take this recommendation forward. At the Ministerial Board in June 2012, DfE officials confirmed that following discussions with Tim Loughton, Parliamentary Under-Secretary of State for Children and Families, DfE had agreed that the PPO should investigate these deaths.

DfE consulted with the Association of Directors of Social Services who thought it would be valuable to put such arrangements in place. Discussions had also been held with SCH managers, who were broadly supportive of having the PPO investigations in future. DfE will now be working with stakeholders to develop protocols as to how these investigations would be undertaken.

The Panel welcome this decision to provide an effective independent investigative mechanism for any future deaths in SCHs. The Panel would like to highlight the importance for arrangements for funding to be established at the outset given the complexities of the commissioner-provider relationships with a range of local authorities.

The Secretariat visited a strategic health authority cluster in May to discuss their arrangements for recording information from Mental Health Trusts about investigations into deaths of detained patients and to identify whether any independent investigations had been commissioned. This was a very informative visit, and confirmed the Panel's concern that no such investigations are being carried out. The Panel will now consider whether to amend its research questions to assess the quality of Trust investigations into serious untoward incidents. The Chair of the Panel also met CQC's Director of Regulatory Development in May 2012, who explained that CQC is in the process of defining its role in relation to deaths of detained

patients. Once appointed, those responsible for investigations in the new NHS Commissioning Board will also be key contacts for the Panel in taking forward this project.

Use of Physical Restraint

In February 2012, the Panel held a meeting with UK Border Agency, DH, Institute of Psychiatry, NOMS, Youth Justice Board, Restraint Advisory Board and ACPO to discuss the Panel's common principles on the use of restraint.

Attendees agreed that the principles were a sensible start and might be helpful standards for commissioners of custodial services to ensure providers offer safe training and practice on restraint. However, further consultation with the DH and CQC highlighted that the principles require amendment to make them relevant for mental health settings. The IAP will meet with CQC, DH, Institute of Psychiatry and Royal College of Nursing in August 2012 to discuss their perspectives on restraint in mental health settings and to capture information about their planned projects for improving consistency of training. The Panel will provide an update to the Board in October 2012, with the aim of gaining support from all service leaders prior to presentation of the final version of the principles in February 2013.

The Panel has also, in conjunction with ACPO, begun to identify ways of improving police reporting mechanisms on the use of restraint. ACPO provided the IAP with a sample of data from one force. The IAP analysed the sample to see if it is possible to identify how often restraint is used and to develop an understanding of whether this data could be routinely submitted by forces for analysis by a suitable national body. The Secretariat met representatives from the force in May 2012 and is following up a number of queries about the data set. At this stage there is insufficient justification for suggesting a national collection but the Panel will continue to look at this area as part of its project on use of restraint.

The Independent Custody Visitors Association (ICVA) check on the rights of detainees in police custody, including their health and wellbeing and the conditions they are detained in. ICVA are undertaking work on monitoring the use of restraint in police custody and have proposed a form for police authority scheme administrators, who have responsibility for collating information from ICVA visits. The form will capture information on: (1) the type of restraint used and length of restraint period (2) whether medical treatment was needed following use of restraint (3) whether the use of restraint was recorded in the custody record and (4) when the restraint was used i.e. during arrest or following authorisation of detention. Forms, once completed, will be sent to ICVA and Her Majesty's Inspectorate of Constabulary (HMIC) for analysis.

The Mayor's Office for Policing and Crime have expressed interest in contributing to a month long pilot to collect this information from 1 September 2012 and ICVA discussed their proposal at the scheme administrator's conference on 3-4 July 2012 to identify further authorities to run the pilot. An update on this will be provided to the Board in October 2012 and the Panel will seek to identify any issues from this work which would benefit from a greater focus and inform its work on restraint data collection.

Information Flow through the Criminal Justice System

Following the initial analysis of a sample of police PER forms, Her Majesty's Inspectorate of Prisons (HMIP) agreed to conduct further fieldwork in prisons and Young Offender Institutions (YOIs) to identify how the PERs originating from police custody were being used as the individual was taken into prison custody. In terms of initial findings, whilst prison staff used the PER as a means of flagging that there is a concern of self harm, detailed information about this risk was being conveyed to the prison in other ways. In the five prisons and YOIs HMIP had inspected as part of this work, SystmOne was being used effectively to convey healthcare information relating to a prisoner. Furthermore, fieldwork also evidenced that prison staff were developing informal systems to convey information within the prison to make up for perceived shortfalls with the PER. The inspections also found that information held on the PER was not being used by staff when completing the Assessment Care in Custody Teamwork (ACCT) process. HMIP would present their findings in full to the Board in October 2012.

Following endorsement of the Panel's information sharing statement from the Information Commissioner and General Medical Council, the Panel will be writing to service leaders to ask them to disseminate the statement and to consider how best to do this in the context of their organisations. The IAP will monitor the implementation of this statement and evaluate the effectiveness of it during its second term.

Joining the Practitioner and Stakeholder Group

There are now over 120 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 practitioners from all organisations as well as 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

Bulletin of tenth Ministerial Board published today

The bulletin of the tenth Ministerial Board was published in July 2012. http://iapdeathsincustody.independent.gov.uk/news/bulletin-of-tenth-ministerial-board-published-today/

NOMS publish latest safer in custody statistics

NOMS published its new Safer in Custody quarterly bulletin in July 2012. http://www.justice.gov.uk/statistics/prisons-and-probation/safety-in-custody

Chair of the IAP meets with Chief Coroner

Lord Harris met with His Honour Judge Peter Thornton QC on 13 July to discuss his appointment to the role of Chief Coroner.
http://iapdeathsincustody.independent.gov.uk/news/meeting-with-the-chief-coroner/

National Confidential Inquiry (NCI) into suicide and homicide by people with mental illness

NCI published their annual report for 2012.
http://www.medicine.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/annual_report_2012.pdf

ACPO response to IPCC statistics

Assistant Chief Constable Dawn Copley, ACPO lead for custody, commented on the IPCC report into deaths during and following police contact for 2011/12.
http://www.acpo.presscentre.com/Press-Releases/ACPO-comment-on-IPCC-report-into-deaths-during-or-following-police-contact-2011-12-18c.aspx

Deaths during or following Police contact: Statistics for England and Wales 2011/12

The Independent Police Compliant Commission (IPCC) has published their statistical analysis on deaths during and following police contact which occurred between 1 April 2011 and 31 March 2012.
http://www.ipcc.gov.uk/en/Pages/reports_polcustody.aspx

Letter from the Chair of the IAP to the new Chief Coroner

In June 2012, Lord Toby Harris, Chair of the Independent Advisory Panel (IAP) on Deaths in Custody wrote to His Honour Judge Peter Thornton QC, the recently appointed Chief Coroner, providing him with an update on some of the Panel's work relevant to his remit.
http://iapdeathsincustody.independent.gov.uk/news/letter-from-the-chair-of-the-iap-to-the-new-chief-coroner/

NOMS publish their review of unclassified deaths

In June, the National Offender Management Service (NOMS) published their review of unclassified prison deaths between 2010 and 2011, following discussion of the recommendations at the Ministerial Board on Deaths in Custody on 12 June. The report was commissioned by NOMS. http://iapdeathsincustody.independent.gov.uk/news/noms-publish-their-review-of-unclassified-deaths/

David Behan announced as the new Chief Executive of CQC

The Care Quality Commission (CQC) announced that David Behan is to take up as the new CQC Chief Executive in July and will replace Cynthia Bower who resigned in February this year.
http://www.cqc.org.uk/public/news/david-behan-announced-new-chief-executive-cqc

Transfer of patient safety function to the NHSCB SHA

On 1 June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) was transferred to the NHS Commissioning Board Special Health Authority (the Board Authority). This ensures that patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA, driving patient safety improvement.
http://www.npsa.nhs.uk/corporate/news/transfer-of-patient-safety-function/

Ministry of Justice appoint Chief Coroner

On 22 May, the Ministry of Justice (MoJ) announced the appointment of His Honour Judge Peter Thornton QC as the new Chief with effect from September 2012.
http://www.parliament.uk/documents/commons-vote-office/May_2012/22-05-12/8.MOJ-Appointment-of-Chief-Coroner.pdf

IAP Meeting 2 May 2012

The fourteenth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place on 2 May 2012. At this meeting, the Panel discussed feedback from their stakeholder consultation event, the IAP work programme for 2012/13, coronial reform and statistics.

Latest edition of 'The Solution' published

The latest edition of 'The Solution', the online magazine for Black Mental Health UK was published in May.
http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/05/The-Solution-Issue-4-May-June-2012.pdf

Bulletin of ninth Ministerial Board published

The bulletin of the ninth Ministerial Board on Deaths in Custody was published in May. http://iapdeathsincustody.independent.gov.uk/news/bulletin-of-ninth-ministerial-board-published-today/

IPCC recommendations shape national guidance on custody handling

The second edition of the ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody was released in March 2012. The guidance focuses on practical issues within custody and aims to provide a definitive guide to police forces on strategic and operation policies to raise standards of care within custody. http://iapdeathsincustody.independent.gov.uk/news/ipcc-recommendations-shape-national-guidance-on-custody-handling-2/

Learning the Lessons Committee publish latest bulletin

In April, the Learning the Lessons Committee 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://iapdeathsincustody.independent.gov.uk/news/learning-the-lessons-committee-publish-latest-bulletin-%e2%80%93-april-2012/

Next Issue

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