November 2012 • Bulletin 9

INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

Welcome to the ninth 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 July 2012.

In August 2012, the Panel met with health stakeholders, including the Department of Health and Care Quality Commission (CQC) to discuss the common principles on the use of restraint. It was a positive meeting and provided the Panel with an insight into how to make them more applicable for use in settings with patients detained under the Mental Health Act (MHA). The Panel will now be consulting on the principles prior to presentation at the Ministerial Board in February 2013.

In October 2012, the Ministerial Board on Deaths in Custody met for the eleventh time. The meeting was chaired by the new Parliamentary Under-Secretary of State at the Ministry of Justice, Jeremy Wright. His Honour Judge Peter Thornton QC, the newly appointed Chief Coroner also attended the meeting. I presented research commissioned by the Panel on learning from Rule 43 reports following a death in custody and made recommendations aimed at improving the impact of these. Learning from deaths in state custody must be made a higher priority for all custodial organisations. The Panel hopes that the appointment of the Chief Coroner will lead to a significant improvement to death in custody inquests including how learning is analysed and implemented to improve practice.

In November 2012, the Panel published an update to their statistical analysis of all recorded deaths in state custody between 1 January 2000 and 31 December 2011. This year we have been assisted by the CQC to identify how data can be standardised for comparison across the sectors. The Panel have also identified future work to be taken forward from the analysis, including exploring the reasons behind the higher number of self-inflicted deaths amongst women detained under the MHA in 2010 and 2011 compared to 2009.

This E-bulletin also provides an update on progress of IAP projects; as well as details of forthcoming meetings with IPCC, the Independent Commission on Policing and Mental Health, and the Chair of the NHS Commissioning Board. There is also an invitation to join our Practitioner and Stakeholder Group and a summary of news items towards the end.

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

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Ministerial Board on Deaths in Custody

The eleventh meeting of Ministerial Board on Deaths in Custody was held on Thursday 18 October 2012 and was chaired by the new Parliamentary Under-secretary of State at the Ministry of Justice, Jeremy Wright.

Lord Harris presented the IAP's report analysing the impact of Rule 43 reports following a death in custody and an update on progress with implementing the IAP recommendations made to the Ministerial Board since March 2010. Inquest also presented their report entitled: 'Learning from Inquests: A New Framework for Action and Accountability (available to download here). His Honour Judge Peter Thornton QC, who took up post as the Chief Coroner in September 2012, outlined his plans for overseeing the implementation of reforms to the coroner system contained within Part 1 of the Coroners and Justice Act 2009 (his speech to the Coroners' Society of England and Wales outlining the plans in full is available to download here).

The Department of Health (DH) and CQC provided an update on their respective positions in relation to independent investigations of deaths of detained patients, and more detail is due at the February 2013 meeting. The National Offender Management Service (NOMS) and DH explained their progress in implementing the recommendations from the review of unclassified prisoner deaths in 2010/11 (the report is available to download here).

Her Majesty's Inspectorate of Prisons (HMIP) presented a report on Person Escort Records (PER) forms in prisons (further details of which is included in the IAP work update) which the Panel welcomes. The IPCC presented their statistics for deaths during or following police contact in 2011/12 and updates were heard from the Prison Reform Trust from their 'Care Not Custody' campaign; the Howard League's report on deaths under probation supervision (available to download here) and DH on the management of persistent pain.

IAP publish 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, available to download here, the Panel made a commitment to develop its level of analysis to make evaluative conclusions about the data. This year we have worked with the CQC Intelligence Team who attempted to analyse, from the available data, whether there is evidence of disproportionality of deaths in all custodial settings by type of death (natural/non-natural) and by gender.

Due to the lack of detail provided in population breakdowns for some sectors it was only possible for CQC to standardise the data by gender. Following consultation with CQC and a range of stakeholders, the Panel decided not to include that analysis because it is missing standardisation by age and ethnicity and could, therefore, present an inaccurate picture. The process of analysis and discussion has led to some delay in publishing this report but the Panel are in a position to specify more clearly what is required from the sectors to fully standardise the data in future.

The report draws on comparison of raw values and has been structured to provide a focus on deaths in custody data for 2011, whilst looking at recent trends between 2009 and 2011 and the wider context of deaths in state custody between 2000 and 2011.

Table 1. (below) summarises the number of recorded deaths in state custody between 1 January 2000 and the 31 December 2011[1].

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Prison:	146	142	164	182	207	174	153	185	165	169	197	192	2076
Police:	30	29	32	34	39	28	26	23	18	16	19	19	313
In-Patient Mental Health Setting (detained patients)	406	346	307	331	310	337	363	325	326	312	303	283	3949
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	17	196
STC / SCH:	0	0	0	0	2	0	0	0	0	0	0	0	2
Immigration detention:	1	0	0	2	4	2	1	0	0	0	2	4	16
Total Deaths in State Custody for England and Wales	**607**	**539**	**524**	**561**	**582**	**558**	**553**	**550**	**524**	**506**	**533**	**515**	**6552**

1. Includes deaths of individuals 18 and over in custody or released on licence for medical reasons. These also include deaths of 15 - 17 year olds held in YOIs. These figures exclude two deaths that occurred in Haslar Immigration Removal Centre, which is run by HM Prison Service in 2003 and 2004. These are included in the immigration detention figures.

2. Deaths in or following police custody as defined in category A of the PACE Act 1984.

3. These figures include deaths of young people in Secure Training Centres (STCs) and Secure Children's Homes (SCHs)

4. These figures include the three prison service run IRCs at Haslar, Dover and Lindholme.

- In total, there were 6,552 deaths recorded for the 12 years from 2000 to 2011. This is an average of 546 deaths per year[2]. Of these deaths, 72% (n=4,724) were men and 28% (n=1,828) were women[3].
- A total of 607 deaths were reported in 2000 compared to 515 in 2011 (which represents 15% fewer deaths in 2011 compared to 2000 although there have been fluctuations between years in that period).
- Deaths of those detained under the MHA and those in prison custody, account for 92% (n=6,025) of all deaths in state custody at 60% (n=3,949) and 32% (n=2,076) respectively.
- 66% (n=4,327) of all deaths were recorded as natural causes. Of these, 70% (n=3,031) of deaths were of patients detained under the MHA and 17% (n=1,091) were of prisoners[4].
- 9% (n=611) of the 6,552 deaths were of individuals from Black and Minority Ethnic (BME) groups, with 5% (n=333) classified as Black, 3% (n=203) as Asian, 1% (n=55) as Mixed Ethnicity and 0.2% (n=13) as Chinese. 86% (n=5,661) were classified as White. Ethnicity was either not known, or not stated in 3% (n=200) of cases[5]. 1% (n=80) were classified as 'Other'[6].

1 These figures have been revised from the previous IAP statistical analysis in 2011 to account for data supplied by the HIW for detained patients under the MHA in Wales.

2 In 2010, one prison natural cause death was reported late to NOMS, which accounts for the additional death in 2010's figures.

3 For data on gender, please see **Appendices 1 – 6** in the report.

4 A breakdown of these deaths can be found in Appendices 1 and 3 in the report.

5 67 were residents of Approved Premises. Up to and including 2002, NOMS did not record data on the ethnicity of Approved Premises residents. There are 16 deaths in or following police custody where the ethnicity of the detainee is not recorded. These cases predated the IPCC, who are in the process of requesting this information from the relevant police forces. Furthermore, the death in or following police custody in 2006 was subject to a local police investigation and was not investigated by the IPCC. They have written to the force to ascertain the ethnicity of the individual. The CQC are revisiting these files to ascertain the ethnicities of 117 patients who died whilst detained under the MHA. These figures will be updated for the updated analysis in 2013.

6 For data on ethnicity, please see **Appendices 1 – 6** and pie charts at **Annex A** in the report.

In consultation with the custodial sectors, the IAP will be requesting population data to enable standardisation for next year's report. This will require some work with co-sponsors to ensure that population data, for the first time, can be provided in consistent formats by NOMS for prisons and approved premises; with UKBA for immigration removal centres and the Home Office and Association of Chief Police Officers (ACPO) to access useful police custody population data. This will enable the Panel to develop its analysis of equality issues to identify any disproportionality by type of death and protected characteristics (i.e. by race, age and gender).

If you have any comments about the report, please contact the IAP Secretariat at iapdeathsincustody@noms.gsi.gov.uk

Update on IAP Projects

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

Cross Sector Learning – Deborah Coles

IAP report on learning from deaths in custody

The Panel commissioned a study on the impact of Rule 43 letters on learning to prevent future deaths. The Panel asked researchers (Mendas) to consider how Rule 43 letters are written, how organisations deal with them and how they are used as tools for learning. The Panel also wanted to identify how learning was being used to inform policy and training, and how it was fed back to operational staff and communicated to bereaved families. The analysis aimed to examine further the impact of Coroners' recommendations in Rule 43 reports; particularly their impact on changes to policy and practice to prevent future deaths in the individual custodial sectors.

The Chair of the IAP presented the Panel's paper to the Ministerial Board in October, which drew out the main findings to be taken forward from this research. The paper was published here.

Mendas analysed a representative sample of 30 written reports and interviewed approximately 45 stakeholders from across the custodial sectors. The researchers thought that those involved in implementing learning in each of the organisations needed a better understanding of how to support staff to make changes as a result of investigations as well as Rule 43 letters. This would ensure that the learning made a real difference to reducing deaths in custody by supporting practitioners to make changes that could be sustained over time, rather than re-stating or amending guidance and policy.

The Panel drew attention to three main areas:

(i) Circulation and access to Rule 43 reports and responses is problematic. The current MoJ six-monthly publication summarising the Rule 43 letters that have been written does not provide sufficient analysis of themes. The Panel would like to see custodial organisations using themes identified to identify key issues for change and have recommended that: **the Chief Coroner's office should develop a fully searchable, publicly accessible, database of all death in custody Rule 43 reports, which includes sufficient information to identify themes and trends for inclusion in the annual report to Parliament. The information should also be accessible to custodial organisations and other relevant organisations for the purposes of learning and research. Processes need to be put in place to ensure that all reports and responses are recorded on the database.**

(ii) The research shows there is a need for greater consistency amongst coroners as to when Rule 43 reports are written to ensure that organisations are signposted to key learning points in deaths in custody cases. The Panel has therefore recommended that: **training for coroners should include guidance about when Rule 43 reports should be made to promote greater consistency in their approach to deaths in custody inquests.**

(iii) The IAP thinks organisations with responsibility for investigating and inspecting custodial settings should have sight of Rule 43 reports to enable them to check whether learning has been sustained over time. A suggested list of copy recipients could be circulated by the Chief Coroner, asking coroners to routinely copy Rule 43 reports about police deaths to the IPCC and Her Majesty's Inspectorate of Constabulary; prison deaths to Prisons and Probation Ombudsman (PPO) and HMIP and deaths of detained patients to CQC. The Panel recommend that: **the IAP in conjunction with members of the Ministerial Board to identify organisations that should be routinely copied to Rule 43 reports in order to support and monitor implementation of the learning – and to pass on details of this suggestion to the Chief Coroner.**

If you have any comments about this report, please contact the Secretariat at iapdeathsincustody@noms.gsi.gov.uk

Family liaison – Deborah Coles

An updated version of good practice standards for family liaison were discussed with DH, PPO, IPCC, NOMS, UKBA and the Youth Justice Board (YJB) on 3 October 2012. This was a positive meeting and helped refine the document to ensure it reflects the specific nature of the family liaison duties of staff in custodial settings compared to those who investigate the deaths. The Panel is awaiting final feedback so that the standards can be presented with an implementation plan to the next meeting of the Ministerial Board in February 2013.

Mental health – deaths of those detained under the Mental Health Act (MHA) including Section 136. – Simon Armson and Dr Peter Dean

Since a meeting in May 2012 with the Health and Social Care Information Centre (HSCIC) and CQC, the Panel has had confirmation that HSCIC has successfully linked data between the Mental Health Minimum Data Set and ONS mortality data regarding premature mortality. This linked data set would be the best data set to use for the re-analysis of natural cause deaths of detained patients and the Panel is awaiting confirmation from HSCIC and CQC about timescales for completion of the work.

In September 2012, Simon met Professor Keith Hawton, the Director of the Centre for Suicide Research at the University of Oxford in September 2012 to discuss the Panel's work on a literature review of studies about mental illness and deaths in custody. This helped the Panel develop its specification and procurement of the review will commence shortly.

In October 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.

At the meeting, ACPO presented their review of Section 136 data; CQC and HMIC provided interim feedback from their joint thematic examining the use of police custody as a place of safety for Section 136 detainees and there was a discussion on how to ensure police custody suites were used as a place of safety in exceptional circumstances only.

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 by attending the next meeting in January 2013, and will consider the outcome of the joint HMIC and CQC thematic inspection of Section 136 in order to identify priorities in this area.

Article 2 Compliant Investigations – Professor Philip Leach

In September 2012, the Panel received an update from the PPO and DH on the clinical review pilots in the North West and South West Strategic Health Authority (SHA) clusters. The model for delivering clinical reviews is being tested and has shown some improvements in timeliness due to improved communication between organisations. The final model will be developed in time for commencement of the NHS Commissioning Board's responsibilities for offender health.

The Department for Education has been taking forward work to implement the recommendation that the PPO should investigate deaths of children in secure children's homes (SCH). They held positive meetings with SCH staff and are liaising with the Ministry of Justice to agree how funding of investigations will be organised.

Investigation of deaths of detained patients

Following the Secretariat's scoping activity about investigations into deaths of detained patients, Professor Philip Leach, Simon Armson and Deborah Coles met in July 2012 to define their planned research in this area. They discussed a lack of evidence to suggest that SHA commissioned independent investigations into Serious Untoward Incidents (SUIs) were taking place (other than for homicides) and that there would be value in assessing the quality of Trust level serious incident investigations to develop guidance that could apply in the new NHS commissioning arrangements. In August 2012, Simon met the Associate Medical Director for Mental Health for NHS London and, Chief Executive of the South London and Maudsley Foundation Trust (SLAM) to discuss further approaches to the research. The Panel is now working with CQC who have agreed to redact a small sample of reports for analysis, which will inform the methodology required for analysing a larger sample and to develop good practice guidance.

Use of Physical Restraint – Professor Richard Shepherd

As referred to in previous E-bulletins, the Panel has been engaging with custody sectors and health bodies to discuss the Panel's common principles on the use of restraint and to ensure they are applicable to all settings. The Panel will now circulate the amended principles to all relevant organisations for consultation and to gain support from all service leaders prior to presenting a final version of the principles to the Board 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. Whilst the data was detailed, it did not provide enough justification for national collation. The Secretariat are in the process of establishing a working group involving the IPCC, Association of Chief Police Officers (ACPO) and police practitioners to identify how to develop a justification for use of force data collation by police forces in order to improve how data on restraint can be used to learn and prevent deaths.

Information Flow through the Criminal Justice System – Professor Stephen Shute

At the Ministerial Board on 18 October 2012, Nick Hardwick, HM Chief Inspector of Prisons presented the HMIP and HMIC report to Board members on their thematic analysis of Person Escort Record (PER) forms. This work was undertaken on behalf of the Panel and key findings included:

- Prison reception staff, nurses and Assessment Care in Custody Teamwork (ACCT) assessors told HMIP that PERs were useful as a means of flagging risk of self-harm and suicide, however they described other documentation, namely clinical records, ASSET (for young people) and the National Offender Management Information System (NOMIS) as being most helpful in informing risk assessment.
- Detailed information about this risk was being conveyed to the prison in other ways. One of the most highly regarded methods by staff was direct contact between court mental health diversion teams and prison reception staff.
- The Assessment Care in Custody Teamwork (ACCT) system[7] was central to the management of risk of self-harm in custodial establishments, but ACCT assessors rarely saw information contained on the PERs and did not usually see the Self-Harm Warning Form[8].
- Healthcare staff are relied upon to assess a potential risk of self-harm in prison, but HMIP found that in the establishments they inspected, many healthcare staff did not attend ACCT review meetings.
- In the five prisons and YOIs HMIP had inspected as part of this work, SystmOne[9] was being used effectively to convey healthcare information relating to a prisoner.
- In focus groups involving police custody staff, Prisoner and Escort Contract Services (PECS) contractors and prison staff, a key theme was staff who recorded information about self-harm did not understand how it was used and therefore, why its quality, content and accuracy was important. Staff also wanted training in order to improve their understanding of the purpose of recording the information and how it is used.

7 ACCT is an individually-based care planning system, designed to help the identification of prisoners who are at risk of suicide or self-harm and ensure that appropriate steps are taken for their care. ACCT was created to facilitate a more multi-disciplinary approach to supporting prisoners.

8 Self-Harm Warning Form's are used to notify receiving prisons of prisoners who may be at risk from self-harm or suicide and to record actions taken during the pre/inter-prison custody period.

9 SystmOne is a national clinical IT system, used in prisons, which allows prison healthcare staff to update and share records relating to a prisoner's physical and mental health.

The Panel welcome the report's findings and will monitor how custodial sectors respond to these at the Ministerial Board in February 2013 to determine if further work is needed in this area. The Panel are planning to identify the efficacy of ACCT for managing risk of self-harm and suicide in 2013. To read the report in full, please visit the HMIP website here.

The Panel's information sharing statement (available to download here) was endorsed by the Information Commissioner and General Medical Council and was issued to service leaders in September 2012. The Panel asked them to disseminate the statement using their internal communications channels to ensure it reaches practitioners who need to implement it. There has been positive feedback, with UKBA incorporating elements of the statement in its new Detention Service Order – the operational policy for UKBA staff. The IAP will be establishing whether the statement has been effectively disseminated through the sectors and assess whether further steps are needed to re-communicate the statement. The Panel will then determine suitable evaluation models to assess the statement's impact through 2013/14.

IAP meetings with stakeholders

(i) Independent Commission on Mental Health and Policing

The Panel has been invited to contribute to the Independent Commission on Mental Health and Policing, which is being chaired by Lord Victor Adebowale (Chief Executive of Turning Point). Lord Harris and members of the Panel will be meeting Lord Adebowale and members of the Commission on 11 December.

(ii) IPCC Review of Article 2 investigations

The Panel will meet with Dame Anne Owers, Chair of the IPCC in December 2012 to discuss their review of the ECHR has been engaged. The review is covering how the IPCC:

- Decides which cases to investigate independently;
- Carries out investigations; works with families;
- Communicates and engages with the public, communities and other interested parties;
- Demonstrates its independence and ensures public confidence in its work and;
- Interacts with other organisations.

The Panel look forward to meeting with Dame Owers to discuss areas from the review with relevance to the Panel's work, in particular family liaison following a death in police custody.

(iii) Meeting the Chair of the NHS Commissioning Board

Lord Harris will be meeting Professor Malcolm Grant CBE, Chair of the NHS Commissioning Board, on 18 December 2012. They will discuss commissioning of healthcare in prisons and police custody.

Details of these meetings will be included in the next E-bulletin in March 2013.

Joining the Practitioner and Stakeholder Group

A number of stakeholders have joined the practitioner and stakeholder group in the past few months, representing NHS Trusts, an immigration removal centre, mental health charities and the Youth Justice Board. 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

IAP publish statistical analysis of all recorded deaths in state custody

The IAP have published an analysis of all recorded deaths in state custody between 1 January 2000 and 31 December 2011. http://iapdeathsincustody.independent.gov.uk/news/iap-publishes-statistical-analysis-of-deaths-between-2000-and-2011/

Safety in Custody Statistics Quarterly Bulletin 25 October 2012

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. The publication contains statistics relating to these incidents up to the period ending June 20112 in 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://www.justice.gov.uk/downloads/statistics/prison-probation/safety-custody/safety-custody-june-2012.pdf

HMIP thematic analysis of Person Escort Record forms published

On behalf of the Independent Advisory Panel (IAP) on Deaths in Custody, the HMIP and HM Inspectorate of Constabulary (HMIC) undertook a thematic analysis on the use of the Person Escort Record (PER) with detainees. The report focuses on the use of PER forms to convey information from police custody to court custody.
http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/per-thematic.pdf

Learning from Rule 43 reports following death in custody inquests

At the Ministerial Board on Deaths in Custody meeting on 18 October the two research reports presented were (1) INQUEST's Learning from Inquests: A New Framework for Action and Accountability and; (2) the IAP's commissioned research on the impact of learning from Rule 43 letters (undertaken by Mendas). INQUEST's Learning from Inquests: A New Framework for Action and Accountability http://iapdeathsincustody.independent.gov.uk/news/learning-from-coroners-rule-43-reports-following-death-in-custody-inquests/

HMIP Annual Report for 2011/12 published

Her Majesty's Inspectorate of Prisons (HMIP) published their annual report for 2011/12. The purpose was to ensure independent inspection of places of detention to report on conditions and treatment, and promote positive outcomes for those detained and the public. http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2011-12.pdf

MoJ reports made under Rule 43 of the Coroners Rules published

In September, the Ministry of Justice (MoJ) published its summary of reports and responses under Rule 43 of the Coroners Rules. This covers the period 1 October 2011 to 31 March 2012. http://www.justice.gov.uk/downloads/publications/policy/moj/summary-rule-43-v7.pdf

PPO Annual Report for 2011/12 published

The Prisons and Probation Ombudsman (PPO) published their annual report for 2011/12. During this time period, the PPO opened 229 investigations into deaths. Of these, 142 investigations have been opened into natural cause deaths and 71 apparently self-inflicted deaths have had investigations opened into them. http://www.ppo.gov.uk/docs/PPO_annual_report_content_web_(09.12).pdf

IAP Meeting 10 September 2012

The fifteenth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place on Monday 10 September 2012. http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-10-september-2012/

DH Suicide Prevention Strategy Published

On 10 September, the Department of Health launched a new cross-government strategy 'Preventing suicide in England' on World Suicide Prevention Day. The new strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy: sets out key areas for action; states what government departments will do to contribute; and brings together knowledge about groups at higher risk, effective interventions and resources to support local action. http://www.dh.gov.uk/health/2012/09/suicide-prevention/

IAP's information sharing statement published

In September, the Independent Advisory Panel on Deaths in Custody published an information sharing statement. This statement is designed to promote greater sharing of information while at the same time ensuring compliance with the relevant law: http://iapdeathsincustody.independent.gov.uk/news/iap-publish-information-sharing-statement/

Aug/Sep 2012 edition of 'The Solution' published
The latest edition of 'The Solution', the online magazine for Black Mental Health UK was published in August. http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/08/BMH-UKs-The-Solution-Issue-5-Aug-Sept-2012.pdf

MoJ reports made under Rule 43 of the Coroners Rules published
The Ministry of Justice (MoJ) published its summary of reports and responses under Rule 43 of the Coroners Rules. This covers the period 1 April 2011 to 30 September 2011. http://www.justice.gov.uk/downloads/publications/moj/summary-rule-43.pdf

Learning the Lessons Bulletin - August 2012
The latest Learning the Lessons Bulletin has been published. This bulletin explores learning from investigations including issues in relation to transporting detainees.
http://www.learningthelessons.org.uk/Pages/Bulletin17.aspx

Letter from the Chair of the IAP to UKBA
The Chair of the Independent Advisory Panel (IAP) on Deaths in Custody wrote to Colin Punton, the new Director of Crime and Enforcement Group at UKBA seeking an update on their review of restraint.
http://iapdeathsincustody.independent.gov.uk/news/letter-from-the-chair-of-the-iap-to-ukba/

National framework to improve mental health published
The Department of Health has published the Mental health implementation framework, which sets out what organisations can do to make the six high-level objectives of the mental health strategy, 'No Health without Mental Health', a reality.
http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf
http://www.dh.gov.uk/health/files/2012/07/Mental-Health-Implementation-Framework-Impact-Assessment-supplementary-note.pdf

Next Issue
The next e-bulletin will be published in March 2013.