COVID-19 SUB-MEETING OF THE MINISTERIAL BOARD ON DEATHS IN CUSTODY – SECURE HEALTH SETTINGS - MINUTES

21July 2020, Via Microsoft Teams

Attendees:
Nadine Dorries MP, Minister of State for Patient Safety, Suicide Prevention and Mental Health (Chair, Items 1-3)

Caroline Allnutt, Deputy Director, Mental Health and Offender Health (DHSC co-sponsor and Chair, Items 4-close)
Rachel Whittaker, Serious Mental Illness, Legislation and Offender Health Team, DHSC
Dave Nuttall, Deputy Director, Dementia and Disabilities, DHSC
Kate Davies, Director of Health & Justice, Armed Forces and Sexual Assault Referral Centres (SARCs), NHSE
Ray James, National Director Learning Disability and Autism, NHSE
Cathy Edwards, Clinical Programmes Director, NHSE
Sarah Warmington, Head of Mental Health, NHSE
Sally Grocott, Head of ALB Sponsorship, Ministry of Justice
Deborah Browne, Offender Health, Ministry of Justice
Rachael Biggs, Offender Health, Ministry of Justice

Juliet Lyon CBE, Chair, Independent Advisory Panel (IAP) on Deaths in Custody
Seena Fazel, Independent Advisory Panel on Deaths in Custody
Jennifer Shaw, Independent Advisory Panel on Deaths in Custody
John Wadham, Independent Advisory Panel on Deaths in Custody
Jenny Talbot, Independent Advisory Panel on Deaths in Custody

Peter Clarke, HM Chief Inspector, HM Inspectorate of Prisons (HMIP)
Sue McAllister, Prisons & Probation Ombudsman (PPO)
Dame Anne Owers, Chair**,** Independent Monitoring Boards (IMB)
Dr Kevin Cleary, Deputy Chief Inspector of Hospitals and CQC Mental Health Lead, Mental Health Policy, Care Quality Commission (CQC)
Derek Winter, Deputy Chief Coroner
Peter Dawson, Director, Prison Reform Trust (PRT)
Frances Crook, Director, Howard League for Penal Reform
Deborah Coles, Director**,** INQUEST
Jacqui Morrissey, Assistant Director, Research & Influencing, Samaritans

Item 1: Welcome and apologies

1.1 The Chair welcomed Board members and thanked them for attending her first meeting of the Ministerial Board on Deaths in Custody. She explained that this was the second standalone Board meeting convened to examine the response to, and recovery from, COVID-19 in custodial settings. The first standalone meeting, looking at the response in prisons, police custody and immigration detention, had taken place earlier on 7 July 2020 and was chaired by Lucy Frazer QC MP, Minister of State for Prisons and Probation, and attended by Kit Malthouse MP, Minister of State for Crime and Policing.

1.2 The Chair stated that the preservation of life has been central to decisions taken by ministers, agencies and departments responsible for all places of state custody during the COVID-19 period. She particularly acknowledged the success of the prison service's response to contain the outbreak, and welcomed the opportunity to reflect on achievements and highlight lessons that could be used to respond to ongoing challenges.

1.3 The Chair outlined that a full meeting of the Board would be convened in the autumn to discuss the progress of its wider workplan, which would also incorporate any wider work that had emerged from discussions at the two standalone COVID-19 meetings.

Item 2: DHSC departmental update

2.1 The Chair invited Caroline Allnutt, DHSC, to introduce an update on the work of DHSC. Caroline outlined how the department's priorities in its response to the pandemic had been to emphasise learning and transparency, in accordance with the key principles of its wider work with the Board. She outlined how DHSC, in collaboration with MoJ, NHSE/I, other departments and health partners, had been working on a response to Sir Simon Wessley's Independent Review of the Mental Health Act via a White Paper. This has been delayed due to COVID-19 but would be published as soon as possible. Publication of statutory guidance for the Mental Health Units (Use of Force) Act had been paused and would be resumed later in the year.

2.2 The Government has taken important steps in supporting mental wellbeing through the Every Mind Matters campaign by providing help and guidance in the community, giving financial support to charities to respond to increased demand for their services, and providing training for staff on psychological first aid. The Government remained committed to the NHS Long Term Plan which included a commitment to transform mental health care, and had recently announced a £250 million input to begin improving the mental health estate by eliminating the use of dormitory accommodation. DHSC had prepared a paper on setting out processes and possibilities for improving the existing systems across the health service for the November 2019 Ministerial Board which was later postponed. They would update this and bring it to the next Board meeting.

2.3 The Chair thanked officials for their efforts in this period, including for bringing forward work at speed initially planned to take place at a later date.

Item 3: Mental Health Inpatient Settings

3.1 The Chair introduced Cathy Edwards, NHSE, to give an update on Mental Health Inpatient Settings. There had been 20 COVID deaths during this period (1st March to 3rd July) in medium- and low-security settings, and no deaths in high security settings or the children's estate. Cathy outlined actions taken to preserve life, such as isolating patients, infection control, PPE use, and social distancing. Secure services had continued to deliver, albeit in an adjusted way. Moving into the recovery phase, careful planning is taking place to ensure that the relaxing of restrictions takes place safely; face to face visits are being restarted and referral numbers are increasing for inpatient admissions mostly due to a current lack of capacity in community services. Focus is on ensuring capacity is available and providing alternatives to admission.

3.3 Cathy stated that it was important to understand what future needs might be and work had been commissioned on modelling capacity with the Centre for Mental Health. She outlined that lessons had been learned about the physical environment, digital methods, delivery of more physical healthcare in mental health settings and strong infection control procedures.

3.4 Juliet Lyon said that it was difficult to understand the data and the distinction between patients in the secure estate and those who were voluntary, and that there was a need to produce better data which was aligned with other custodial sectors. She questioned how services could fully learn from the crisis without full data. Focus now had to be on improving mental health in all settings, including prisons. Kevin Cleary, CQC, stated that statutory notification was usually prompt and that they were committed to publishing data as soon as they had it.

3.5 Deborah Coles asked about the Mental Health Units (Use of Force) Act 2018; Caroline stated that they planned to consult on the statutory guidance and commence the Act as soon as possible. She said she would be happy to discuss this with Deborah separately.

Item 4: People with learning disabilities and/or autism in inpatient settings

4.1 The Chair introduced Dave Nuttall, DHSC, to give an update on people with learning disabilities and/or autism in inpatient settings. Dave outlined that there were 2,100 people with learning disabilities and/or autism in inpatient settings, and that there had been 625 deaths between 16th March and 3rd July due to COVID-19 reported to the Learning Disabilities Mortality Review (LeDeR) programme. Next stages were the development of support for people being discharged into the community. He suggested there were helpful lessons to be learned around capturing the best elements of virtual working and digitising Mental Health Act processes, though acknowledged that face-to-face work should be restored where appropriate. Dave acknowledged that data had been an issue during the COVID-19 period; PHE were now undertaking work on gathering different sources of data, including a breakdown across protected characteristics, which would be published by the end of July.

4.3 Deborah asked about data on restraint, as formal reporting through the mental health services dataset currently only reported to the end of April. The Justice Committee on Human Rights had an inquiry into detention of children and young people and had issued a report in June. Asked about the number of reviews that had taken place under the LeDeR programme following a death, Ray James, NHSE, stated that they had made a public

commitment that all reviews would be completed by end of the year. They were working more closely with the Coroners' Office who had been notified and appropriately involved.

4.4 Juliet said that clear, ongoing communication of information is vital and is an issue that also cut across prison health; Ray explained steps that had been taken to ensure communications were accessible to all: a weekly webinar had been held with stakeholders to share best practice from charity organisations and be a conduit for guidance. Specific material and wider Government communications had been shared with employees with learning disabilities and/or autism for comment on its suitability.

4.5 Deborah asked about the use of seclusion in Learning Disability settings and reinforced the urgency of commencing the Use of Force Act. DHSC clarified that data reporting on restraint and restrictive practices to the end of April had been published the previous week and that LD/A was a subset of this data. Jenny Talbot, IAP, asked whether there had been an increase in admissions to inpatient care for people with LD&A. Ray stated that there was a reduction in inpatient numbers during the height of COVID-19, mostly in children and young people settings, though there had been a small increase during June and it was anticipated that there would be increased demand going forward.

Item 5: Prison healthcare

5.1 The Chair introduced Kate Davies, NHSE, to give a further update on prison healthcare following the previous sub-meeting of the Board. Kate emphasised the importance of the cross-government partnerships during this period which had been utilised well. The latest data showed there had been 24 COVID-19-related deaths in prison (at least 12 had pre-existing health conditions) and 20 self-inflicted deaths. 93 prisons had now moved back to some stage of unlock. There had been 77 non-COVID related deaths – the largest number of these were due to unknown causes although it was clear that many were from cancer. She acknowledged that it was important to ask questions about screening and information for all long-term conditions, especially as movements increase.

5.2 The health and justice COVID-19 response sub cell continued to operate and deliver a five-point plan, including work examining enhancing primary and end of life care and increasing hospice care. User Voice, Clinks and Revolving Doors had all provided feedback. The prison population had largely been compliant in following communications. Kate felt substance misuse and mental health would be the biggest risks going forward - there had been a decrease in substance misuse but an increase in alcohol use - and less risk around misuse of prescribed medication. NHSE were working with HMPPS to ensure prisoners released early were engaged with the required health services pre-and post-release to ensure continuity of care and others were ensuring that prisoners were accommodated upon release if they were at risk of homelessness. HMPPS have also been expanding the capacity of the prison estate through temporary accommodation, reviewing remand cases, ensuring access to timely hearings and making greater use of community measures. Seena Fazel, IAP, suggested that recently released prisoners should be given information on COVID-19 risks.

Action 1: Kate Davies to share the latest information on prison deaths during the COVID-19 period prior to the next Board meeting.

Item 6: AOB

6.1 The Chair summarised the discussion and highlighted the recurring theme of data. She acknowledged that there were many data sources and services should reflect on how these can best be brought together.

6.2 The Chair asked attendees for suggested priorities to be covered at a full meeting of the Board in the Autumn. Deborah referred to the Angiolini Review and asked specifically for a discussion on how organisations learn from deaths – bringing together investigations, Prevention of Future Death reports and coroners' reports.

6.3 There were no further items of Any Other Business.

Action 2: Board members to contact Secretariat to suggest priorities for a full meeting of the Board in the autumn.