INDEPENDENT ADVISORY PANEL ON

DEATHS IN CUSTODY

In November, Kate Lampard, was appointed by the Secretary of State for Justice as the chair of the Independent Advisory Panel on Deaths in Custody, replacing Lord Harris.

The appointment is for six months during which time a permanent recruitment process will be run.

Foreword from the Chair of the Panel

In taking on this role, I must first commend the work of my predecessor, Lord Harris, for his leadership of the Panel since its inception and for developing its work over the past seven years, bringing about not only practical advances but also shifting hearts and minds, particularly in the engagement and treatment of families.

With each death reported we get an illustration of how the panel's work sits amid some of the most complex and deeply sensitive issues a public service can face, and into which the Panel is required to inject an authoritative and independent perspective. While there are competing priorities and pressures, I do not doubt that everyone with an interest in this subject holds the same single, shared objective, regardless of their profession, employer or interest.

During my short period as an interim chair, and before a permanent post holder is identified, I feel it important to look at the IAP's priorities and discuss with Ministers and stakeholders where and how we can best work together to reduce the number and rate of deaths in custody. In doing this, I will be talking to as many people as I can and I hope to hand over a panel able to provide timely, relevant and compelling advice.

Should you wish to comment on any of the issues affecting the panel or have any questions for the panel, please do not hesitate to contact me.

Kate Lampard
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Update on Work of the IAP

Panel member changes

As well as the interim appointment to maintain the leadership of the Panel following Lord Harris stepping down at the end of his term, three panel members – Deborah Coles, Richard Shepherd and Philip Leach – all came to the end of their tenures in September 2015.

All these members were at the Panel's inception in 2009 and its achievements are due to their energy and commitment.

As the appointments to the panel are regulated by the Commissioner for Public Appointments, these vacancies will be advertised on the public appointments website and filled through an open competition in due course.

Those registered with the IAP on our stakeholder and practitioner group will be alerted when all IAP adverts are on-line.

Reviewing the IAP as a public body

It is recognised that all government arms length bodies should be periodically reviewed to make sure they are still necessary and effective, and this is typically through a Triennial Review.

The Ministerial Board on Deaths in Custody in June reported that the Independent Advisory Panel, as an arm's length body, would be included in the Ministry of Justice's Triennial Review programme, with a view to it commencing in September 2015. At that stage the Departmental sponsors of the IAP (Justice, Health and the Home Office) decided that it would be prudent to wait until the review's outcome was understood before undertaking any new recruitment.

However, in July it was agreed to delay the Triennial Review while the wider reforms under the new government began to take shape. The IAP Triennial Review is, therefore, on hold awaiting the strategic picture on prisons and their governance to emerge. To fill this gap, sponsors and panel members suggested that a light touch "stock take" of the panel's work since 2009 would be appropriate. This will examine which activities have achieved their intended goals and what, if any, lessons might be learned. The stock-take will also look at the relationships between the panel, the secretariat and the Ministerial Board. This exercise is underway, involving current and past panel members, and it is hoped it will also inform the Panel's work programme for 2016.

Meetings

Panel Meeting – September 2015

The Panel met on 9 September; the Chair advised Panel members that the Harris Review *on Self-Inflicted Deaths in NOMS Custody of 18-24 year olds* was published on 1 July, and reflected on the contributions made by the outgoing Panel members. The Panel received an oral update from the Ministry of Justice regarding postponement of the triennial review of the IAP and from the Home Office on their Independent Review of Deaths and Serious Incidents in Police Custody and were assured that the review would engage with the Panel. The Chair fed back from the June Ministerial Board meeting. Discussions took place regarding the update on workplans and plans for taking forward new workstreams.

Copy of the full minutes can be found on the IAP website.

Ministerial Board – October 2015

The Board was attended by all the three Ministers for the sponsoring departments (a first) and was chaired by Mike Penning, Minister for Policing, Crime and Criminal Justice at the Home Office. Senior leaders from each of the custodial sectors presented a short report on their in-year statistics and issues on deaths in custody. The Home Office gave an update on the *Independent Review of deaths and serious incidents in police custody* which was announced earlier in the year by the Home Secretary. The Board also heard from the HMIC on their thematic inspection on the *Welfare of vulnerable people in police custody* and Professor Louis Appleby gave a presentation on current trends in suicides in the general public and the relationship with those in prison custody.

A copy of the paper presented at the Board by the Prison and Probation Ombudsman is on the IAP website.

Consultations/Stakeholder engagement

Conference on Acute behavioural disorder – myths and reality

A conference, in association with the Clinical Forensic and Legal Medicine Section of the Royal Society of Medicine and the IAP, took place on 7 November 2015. The aim was to develop a definition of Acute Behavioural Disorder (ABD) and its management with the following objectives:

- Discuss the pre-hospital and medical management of ABD
- Review the cause of death in ABD
- Discuss the legal issues of a death in custody
- Explore the impact of restraint on ABD
- Discuss the use of restraint techniques in particular TASER on restraint

It was a unique meeting, bringing together for the first time ambulance personnel, police officers, custody officers, emergency medicine doctors, pathologists, psychiatrists, lawyers, IPCC, coroners and toxicologists to examine the themes. Some of the issues raised and discussed were:

- Acute Behavioural Disorder as a term should remain as it was widely understood.
- ABD was a medical emergency and early control, whether physical or medical, was important to prevent build up of exertional metabolites (lactic acidosis). Maintaining good breathing was vital to ensure that this did not occur.
- Ketamine was considered a good drug to use as it did not reduce respiration.
- A joint best practice guideline was being prepared between the Royal College of Emergency Medicine and the Faculty of Forensic and Legal Medicine. The Faculty would seek to gain endorsement for pre-hospital emergency care, and other ambulance services present would also promulgate learning from this meeting.
- London Ambulance had 24 specialist medical paramedics who could respond to ABD emergencies.
- The NHS needed to develop the skills, capacity and infrastructure to manage restraint and/or movement of patients so that police were not called to apply restraint in mental health settings.

- Deaths in mental health facilities were not sufficiently scrutinised.
- NICE guidelines stated that restraint could be applied for 10 minutes; this was considered too long and unsafe.

A fuller version of the notes of this meeting will be placed on the IAP website.

Practitioner and stakeholder group

There are currently approx 150 members of the practitioner and stakeholder group, drawn from inspectorate and investigative bodies, lawyers, Third Sector organisations, families, academics and practitioners from the custodial sectors. The Panel would like to encourage practitioners from a range of organisations, particularly mental health settings, as well as families to join the group.

As a member of the group you can expect to receive the IAP regular mail-shots with links to relevant news and publications from across the sectors; updates from the IAP website and invitations to stakeholder events.

If you would like to join the practitioner and stakeholder group please contact the Secretariat at *iapdeathsincustody@noms.gsi.gov.uk*.

IAP learning library

The Secretariat acts as a resource for the sharing of learning and information about the means of preventing deaths in custody. In June 2011, the Secretariat launched the **IAP's Learning Library**, which contains learning documents from the criminal justice agencies and third sector organisations which may have cross sector applicability. If you think there are documents that should be included in the library, please contact the Secretariat via *iapdeathsincustody@noms.gsi.gov.uk*.

NEWS

ANNUAL REPORTS AND STATISTICS

The Prisons and Probation Ombudsman (PPO) publish their annual report for 2014/15

The Prisons and Probation Ombudsman (PPO) have published their annual report for 2014/15. The report gives a breakdown of 250 deaths which occurred in 2014–15 and covers topics such as early days in custody, ACCT, mental health, segregation units and restraints.

http://www.ppo.gov.uk/wp-content/uploads/2015/09/PPO_Annual-Report-2014-15_Web-Final.pdf

Safer in Custody Statistics England and Wales

The Safety in Custody statistics covers deaths, self-harm and assaults in prison custody in England and Wales. This publication updates statistics on assaults and self-harm up to June 2015 and statistics on deaths in prison custody up to September 2015.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472713/safety-in-custody.pdf

PPO Bereaved Families Survey 2013-2015

The bereaved families' survey is one of several stakeholder surveys used by the PPO to help deliver high quality services. The PPO's family liaison officers (FLOs) act as a link between the bereaved family and their fatal incident investigators. This report gives a summary of 69 responses that were received between April 2013 and March 2015.

http://www.ppo.gov.uk/wp-content/uploads/2015/08/PPO_Bereaved-Families-Survey-2013-15_Final.pdf

PPO Post-investigation Survey 2014-15

This report presents the findings of the first year of data collected from the PPO's Post- Investigation Survey, in which a number of stakeholders were asked to comment on their experiences of a specific fatal incident investigation with which they had been involved.

http://www.ppo.gov.uk/wp-content/uploads/2015/07/PPO_Post-Investigation-Survey_21.07.15.pdf

IPCC publish statistics on deaths during or following police contact in England & Wales 2014/15

The Independent Police Complaint Commission (IPCC) has published their statistical analysis on deaths during and following police contact which occurred between 1 April 2014 and 31 March 2015. During this period.

- Seventeen people died in or following police custody.
- Eight people were identified as having mental health concerns.
- Sixteen people were known to have a link to alcohol and/or drugs they had recently consumed, were intoxicated from, were in possession of, or had known issues with drugs or alcohol at the time of their arrest.
- Ten people had been restrained by officers before their death.
- Two incidents involved the use of Taser, of which one also included the use of a police dog.

http://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_1415.pdf

Report of the Chief Coroner to the Lord Chancellor – Second Annual Report: 2014-2015

Under the law coroners have two main functions. First, in relation to each death reported to them they explain the unexplained. If the death is not from natural causes, if it is unnatural, violent, in custody or of unknown cause, coroners will investigate so that answers are found, both for bereaved families in the first place but also for the wider public. Secondly, where appropriate, coroners report to prevent future deaths. This is an important part of their work and one which has been repeatedly emphasised by the Chief Coroner in training and discussion.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/443090/chief-coroner-report-2015.pdf

LEARNING

Review of the Expectations for police custody

Her Majesty's Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary (HMIC) have been leading a review of the Expectations for police custody over the last year. The Expectations set out the assessment criteria, or indicators, for joint inspections of police custody and also 'what we expect to see' in those areas during the inspection. They would welcome your feedback on these areas as well as any other comments you may wish to offer. Please respond to *hmiprisons.enquiries@hmiprisons.gsi.gov.uk* by Friday, 11 December 2015.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468591/expectations-in-police-custody-consultation.pdf

Prison Reform Trust – Relative Justice

The study on which this report is based heard from family members, including parents, grand-parents, siblings and partners of young people and adults with particular needs in contact with criminal justice services. Their personal accounts were at times harrowing: some described the long periods, sometimes years, spent trying to secure effective treatment and support for their loved ones; most highlighted the lack of information as they tried to navigate their way through the justice process, and the confusion and uncertainty they often felt as a result. Many described the negative impact that their relatives contact with criminal justice services had on themselves and their families, and on small children, in particular.

http://www.prisonreformtrust.org.uk/Portals/0/Documents/relative%20justice.pdf

The Harris Review Report published

The report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds (the Harris Review) was published on 1 July 2015. The Review started its work in April 2014 and presented its report to the Minister for Prisons, Probation and Rehabilitation exactly twelve months later. It had been asked to examine whether appropriate lessons had been learned from the self-inflicted deaths in custody of 18-24 year olds that had occurred after ACCT was fully rolled out in April 2007, and if not, what lessons should be learned and what actions should be taken to prevent further deaths.

http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/07/Harris-Review-Report2.pdf

GUIDANCE

IPCC guidelines for handling allegations of discrimination

The IPCC have released guidelines that set the standards that complainants, families and other interested parties should expect when allegations of discrimination are made against the police.

http://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/Guidelines_for_handling_allegations_of_discrimination.pdf

College of Policing – National Guidance on detention and custody

The College of Policing has published a new national guidance on the detention and custody process, from arrest through to bail. The guidance was developed in consultation with stakeholders including the National Police Chiefs' Council, the Independent Police Complaints Commission, the Home Office, the Police Federation for England and Wales and Forensic Healthcare Services.

http://www.college.police.uk/News/College-news/Pages/New_national_guidance_on_detention_and_custody.aspx

IAP Parliamentary Log – November 2015

This Parliamentary Log provides a summary of all Parliamentary business on issues relating to deaths in state custody since May 2015. The log includes information on Parliamentary Business and Written Ministerial Statements from the UK Parliament.

http://iapdeathsincustody.independent.gov.uk/news/iap-parliamentary-log-november-2015/

The Independent Advisory Panel

Chair

Kate Lampard QC

Kate Lampard spent 13 years in practice as a barrister before moving into the public sector where she held a number of non-executive appointments. She now undertakes investigation and consultancy work related to organisational, management and service arrangements and their effectiveness. Kate worked on a lessons learnt report for the Secretary of State for Health arising from the publication of the Jimmy Savile investigations.

Kate has previously been the chair of the South East Coast Strategic Health Authority, vice chair of the South of England Strategic Health Authority and a non-executive director and vice chair of the Financial Ombudsman Service Limited. She is a trustee of the Esmee Fairbairn Foundation.

Panel Members

Stephen Cragg QC

Stephen Cragg is a barrister specialising in public law, and human rights and sits as a part-time judge for the mental health review tribunal. Stephen has been a member of the Independent Advisory Panel on Deaths in Custody since 2014.

Matilda MacAttram

Matilda MacAttram is founder and director of Black Mental Health UK (BMH UK), a human rights campaigns group established in 2006 to raise awareness and address the stigma associated with mental illness in the UK's African Caribbean communities. Matilda has been a member of the Independent Advisory Panel on Deaths in Custody since 2014.

Dinesh Maganty

Dinesh Maganty is Lead Consultant for intensive care for Birmingham and Solihull Mental Health NHS Foundation Trust Secure Care Services and a member of the National Clinical reference group for Health and Justice for NHS England. Dinesh has been a member of the Independent Advisory Panel on Deaths in Custody since 2014.

Meng Aw-Yong

Dr Meng Aw-Yong is a practising Forensic Medical Examiner and Medical Director for the Met Police and is currently working in Emergency Medicine at Hillingdon Hospital. Meng has been a member of the Independent Advisory Panel on Deaths in Custody since 2014.

Graham Towl

Professor Graham Towl is Pro Vice Chancellor and Deputy Warden at Durham University. He is a Professor of forensic psychology and former Chief Psychologist at the Ministry of Justice. Graham has been a member of the Independent Advisory Panel on Deaths in Custody since 2014.