
INDEPENDENT ADVISORY PANEL ON

DEATHS IN CUSTODY



Message from Chair of the Panel

Welcome to the fourteenth e-bulletin designed to give you an update on what the Panel has been doing since November 2014.

As you will be aware, this year for the Panel has been dominated by our work on the review into the self-inflicted deaths of young people and the report's recent publication. We separated this review from the other work of the panel and the report and all allied information is available on special pages of the Panel's website.

For the purposes of the Harris Review my tenure and that of three other members was extended until September 2015 and as that approaches we are keen to establish how the panel will be renewed under the new Government. I am confident that, given the gravity of the issues at stake and the amount to be done, the work will continue.

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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Update on IAP Projects

The IAP workplan 2015-16¹ is published on the website.

Below is a summary of the progress made by the IAP since the last e-bulletin in November 2014

Use of Physical restraint and tasers

The Panel have been working with ACPO and the College of Policing to look at recording the use of force and the data requirements that should be included in guidance. The Panel had confirmation that the updated draft Authorised Professional Practice (APP) on Detention and Custody now includes an obligation on forces to record and report on all instances of use of force. The APP will be published in July 2015 and the Panel will be sent a copy of the draft to comment on.

The use and discharge of tasers by police forces is becoming more prevalent, with far more routinely carried. In 2014 the IPCC commenced a project on the use of force, to which Panel members Philip Leach and Richard Shepherd have been contributing.

Use of Taser will be covered under the terms of reference of this study which is due to report in summer 2015. The Panel are concerned about the increasing use of Tasers which were originally intended as a non-lethal alternative to firearms but are now at risk of being mainstreamed into police practices, which could mean more use on vulnerable groups. There is currently insufficient research or monitoring of its use and the Panel would like to see research on the psychological impact on both children and adults following Taser deployment.

The Panel is working with the Metropolitan Police Service (MPS) Taser Reference Group and members attended their expert session in March to contribute to ideas on how its use could be monitored. The Panel have also taken up permanent membership of the joint MPS Firearms and Taser Reference Group.

Information Flow through the Criminal Justice System

The Chair met with the HM Chief Inspector of Prisons earlier this year to look at progress on his recommendations on the Person Escort Record (PER). Following this meeting the Chair wrote to NOMS Head of National Operational Services about NOMS taking the lead on these recommendations reporting back to the next Ministerial Board meeting in October on behalf of all the Departments involved.

Cross Sector Learning

The Panel has made a number of recommendations to the Board aimed at improving learning, particularly any thematic learning that could be drawn from Coroners' reports.

The Panel commissioned a study to look into how organisations implement lessons learned from Coroners' reports. This suggested more work was needed in cross-sector learning.

While it is positive that organisations have learning arrangements in place, there are yet no clear arrangements in place for commissioners, providers and regulators to share and embed lessons learned that have relevance across the custodial settings and for those detained under the Mental Health Act.

¹ <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/06/IAP-Workplan-2015-16.pdf>

To explore this further the Panel hosted a working group meeting in May 2015 to explore questions such as:

- Is there a mechanism to pick up cross-sectoral issues
- What are the practical barriers to learning
- What is understood about any arrangements that currently work well, and
- Are there any existing models that enable complex organisations to learn lessons?

Many of the organisations had local arrangements but all felt that nobody had yet “cracked” the issue. The panel have subsequently agreed that they will facilitate further cross-sector talks and will work up a proposal for a literature review of learning mechanisms within complex organisations.

Article 2-Compliant Investigations

Investigations of deaths of detained patients

The Panel have been looking at the issue of how trusts undertake an independent investigation following the death of a detained patient. Last year the Panel submitted a formal response to the NHS England draft Serious Incidents Framework (SIF) and followed this up with a meeting with the NHS England Director of Patient Safety. In February 2015 NHSE reported back to the Ministerial Board that the Secretary of State had requested that they take the lead on a piece of work to look into the possibility of creating an independent patient safety investigation unit, along similar lines to the air accidents branch. NHSE are at the beginning of this piece of work and the IAP will be following its development closely.

Secure Children’s Homes

The Panel has been pushing for some time now for the Prisons and Probation Ombudsman’s remit to be extended to cover investigations of fatal incidents in all secure children’s homes and this was confirmed in new regulations in April 2015.

The Panel welcomes the Department for Education’s amendment of the regulations and their commitment to work with the PPO on developing a Memorandum of Understanding setting out their responsibilities in relation to deaths.

Mental Health

Mental health round table discussion

The Panel hosted a round table event on 23 March with custodial organisations, academics and charities to discuss

- What should be done to equip staff to better understand those in their care with mental health issues, and
- What support was in place for staff in relation to their own mental well-being.

The roundtable resulted from a presentation by the Panel to the Ministerial Board about literature review they had commissioned on the role of mental health and deaths in custody. The review had shown that although there was undoubtedly a link between detainee mental health and wellbeing, and deaths in custody, this relationship was complex. The Panel wanted to explore the relationship between improving staff attitudes towards mental health and reducing stigma, and how this could have a positive effect on the care they provided for vulnerable detainees.

There was a consensus that supporting staff mental wellbeing was crucial to enabling them to work effectively with detainees. Supervision opportunities for staff could help build their resilience and enable them to operate effectively despite the difficult experiences common to their working environments. The roundtable showed there were a range of initiatives aimed at supporting staff to work effectively with detainees who were vulnerable due to their mental health (e.g. Five Minute Intervention and the Vulnerability Assessment Framework). Those with managerial responsibilities seemed to be aware that a range of mental health issues existed. The charity MIND was working with the blue-light services to overcome the stigma of mental health issues. There had been a lengthy discussion about the need to prevent people from entering the justice system.

The Panel agreed that they would highlight successful initiatives undertaken in different sectors and promote their use. The panel will be developing and refining this work at their next meeting.

New Workstreams

Equalities

As in all areas, equality concerns cross cut all areas of work and frequently merit additional scrutiny and monitoring in order to understand how differences in treatment can be created or exacerbated.

The Panel is in the process of drawing up a statement on how equality issues may apply to deaths in custody. Once developed it will be published on the website and the Panel will be inviting feedback. We will be interested in hearing from anyone with views on this subject which might help us begin to explore the subject.

Thematic review of reports of Self-Inflicted Deaths of detained patients in mental health hospitals

The Panel are planning a new workstream to conduct a thematic review of Serious Incident Reports of all deaths of detained patients in hospitals to identify themes and trends from a regional and national level. The panel will work on the review with external researchers and analyse reports from a range of different Trusts from around the country.

This piece of work will fit alongside the indicator being developed by the CQC in collaboration with NHS England. The Panel believes that analysis of these reports will highlight the quality of the review process and provide the panel with some much-needed data in this area.

Older prisoners

Research has shown that there is an inflated risk of self-inflicted deaths among prisoners as they get older. Older prisoners are generally an “at-risk” group with high numbers of deaths from natural causes as well as self-inflicted. The Panel will be approaching analysts for statistics on the rates of self-inflicted deaths among older prisoners to look for any themes and will also be looking at end of life issues at the next Panel meeting in September.

Deprivation of Liberty Safeguards

The Panel met the CQC in early 2015 to discuss their role in monitoring the use of the Mental Capacity Act and Deprivation of Liberty Safeguards² (DoLS). The CQC had seen a 10% increase in applications in a year and were hoping that there would also be an improvement in the notifications of deaths. This follows the Supreme Court judgment in *P v Cheshire West and Chester Council and P and Q v Surrey County Council*. The Panel believes this judgment redefines the concept of ‘detention’ to include individuals subject to the Mental Capacity Act.

The Panel also notes the Chief Coroners’ recent guidance about the [Deprivation of Liberty Safeguards](#)² in which he states that any person subject to DoLS is in state detention for the purposes of the Coroners and Justice Act 2009, and the coroner should undertake an investigation into the deaths of such persons.

Statistical Analysis of Deaths 2000 – 2013

On 9 February, the Panel published its fourth annual bulletin on statistics of deaths in all state custody covering the period 2000-2013³.

There have been some changes to the format of the report this year. The Panel has produced three-year average figures and rates by 100,000 where population data is available.

This has helped to draw sound conclusions about how deaths in custody have changed over time and the use of rates by 100,000 will enable comparisons to deaths in the community in due course. This report has highlighted:

- 523 deaths in custody in 2013, 30 less than in 2012.
- Between 2000-2013 approximately 60% of deaths have been of detained patients and 30% have been of prisoners.
- The number of deaths of patients detained under the Mental Health Act reduced to 282 (from 341 in 2012).
- There were 215 deaths in prison and YOIs, which included 75 self-inflicted deaths (SIDs).
- 63% (331) of all deaths in 2013 were due to natural causes. 190 of these deaths were of detained patients.
- 23% (119) of the all deaths were self-inflicted. The number of self-inflicted deaths in prison in 2013 was 75, compared to 60 the previous year. There were 42 SIDs of detained patients in 2013, which is lower than 53 recorded in 2012.
- Most self-inflicted deaths in prisons were of males (73 of 75 in 2013) compared to 28 male SIDs and 14 female SIDs of detained patients in the same year.

² <http://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf>

³ <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/Statistical-analysis-of-recorded-deaths-2000-to-2013.pdf>

The Panel continues to receive quarterly updates from a range of providers about deaths in all state custody. They have had productive discussions with CQC about the data they hold on detained patients and will be working with them to reconcile annual data provided to the Panel in the past with the CQC's own reporting in the Mental Health Act annual report. There may have been problems due to inclusion of deaths of patients subject to Community Treatment Orders. This needs to be rectified and amended in the next annual publication.

Review of Panel activities between 2012 and 2015

The Panel published its End of Term Report in May 2015. The report covers progress on the work of the Panel during its second term, from April 2012 to March 2015. As well as presenting an update on the Panel workstreams the report also looks at the IAP's engagement with their stakeholders, some priority areas for future work and its increased scope. Copy of the report can be found [here](#)⁴.

Meetings

The Chair has undertaken a series of annual bi-lateral meetings with key stakeholders since November 2014, many of which are reported in this bulletin, and all of which have led to development of the IAP workplan this year. Panel and Ministerial Board meetings are detailed below.

Panel Meeting – December 2014

The twenty-fourth meeting of the IAP took place on 10 December 2014. The Panel discussed the IAP Code of Practice and Register of Interests; they heard updates on workstreams on restraint, information flow,

mental health, equalities and investigations of deaths of detained patients. The Panel also looked at workstream strategy, the appointment and recruitment timetables for new Panel members and Chair and the IAP work programme for 2015/16. <http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-10-december-2014/>

Panel Meeting – March 2015

The Panel met again on Wednesday 11 March 2015. The Chair updated the Panel on discussions at the Ministerial Board on Deaths in Custody in February 2015. The Panel discussed the triennial review of the IAP, the immigration data review and HOMES training programme, the arrangements for learning lessons to prevent deaths in custody & identifying key learning themes, and the EHRC's report into the inquiry of preventing deaths in detention of adults with mental health conditions.

<http://iapdeathsincustody.independent.gov.uk/news/iap-meeting-11-march-2015/>

Panel Meeting – June 2015

The Panel's next full meeting took place on 9 June 2015. The Chair updated the Panel on the discussions at the meeting of the Co-sponsors of the Ministerial Council on Deaths in Custody held in the first week of June 2015. The Panel received an oral update from MoJ Arms Length Body Governance Division regarding the triennial review of the IAP and discussed options for the Chair's replacement. The Panel considered the Family Liaison work and the issues and future work on Taser. The Panel also received updates on the Workplans and considered some potential future work around reviewing Serious Incident reports of all deaths of detained patients in hospitals and the self-inflicted and natural cause deaths of older prisoners.

⁴ <http://iapdeathsincustody.independent.gov.uk/news/iap-end-of-term-report-2015/>

Ministerial Board – February 2015

The eighteenth meeting of the Ministerial Board was held on 23 February 2015. It was chaired by the Minister for Prisons, Probation and Rehabilitation, Andrew Selous MP. The agenda covered updates from departmental co-sponsors about proposals for a Triennial Review of the Council, a presentation on how lessons learnt were disseminated across the sectors and the Equality and Human Rights' Commission inquiry into adult deaths in detention.

Ministerial Board – June 2015

The nineteenth meeting of the Ministerial Board was chaired by the Parliamentary Under Secretary of State for Care Quality at the Department of Health, Ben Gummer MP.

The agenda covered the NHS Serious Incidents Framework and the use of restraint in mental health settings, the Panel's Learning Lessons workshop and an update on the Harris Review report into Self-inflicted Deaths in Custody of 18-24 year olds. The PPO also presented the key issues in deaths investigated in 2013/14.

Consultations/Stakeholder engagement

- Healthwatch: A meeting took place between the Chair and Anna Bradley, Chair of Healthwatch regarding independent investigations of deaths of individuals held under the Mental Health Act.
- The Chair met Mike Durkin, Director of Patient Safety, on 24 November. He provided reassurance about NHS England efforts to address weaknesses in learning from deaths of detained patients and the system wide approach to improving safety, such as Patient Safety Collaboratives. However, since

the Panel's original submission, the document was re-drafted following announcements about the restructuring of NHS E commissioning, which means that independent investigations would need to be commissioned by Clinical Commissioning Groups (CCGs) instead of regional teams. The Panel raised concerns that this would be a barrier to system wide learning.

- The Chair met the Crown Prosecution Service (CPS) Head of Special Crime and Counter Terrorism Division in October in order to understand in more detail the CPS processes for investigating deaths in custody; the issues relating to corporate manslaughter prosecutions and their arrangements for family liaison.
- The Chair met with Stephen Shaw for a preliminary consultation on his review of welfare and safety in IRCs.
- The Panel contributed to the EHRC Inquiry into Adult Deaths in Detention, and have met a range of organisations to ensure the HMIC, IAP, Harris Review and EHRC work on deaths is as coordinated as possible.

National Suicide Prevention Strategy Action Group

The Panel Secretariat attends this group, chaired by Professor Louis Appleby. Professor Appleby is due to attend the October meeting of the Ministerial Board to provide the wider context to trends in self-inflicted deaths. As well as reviewing national suicide statistics, the Strategy Group's agenda has recently covered recent trends, the Suicide Prevention Tool, the role and impact of social media on suicide and working with the press and media on reporting suicide.

IAP Appointments

Lord Harris's appointment is due to end at the end of September along with the terms of three of the Panel members, Deborah Coles, Philip Leach and Richard Shepherd. Recruitment for their replacements is currently being considered.

Practitioner and stakeholder group

There are currently over 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 bi-monthly 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 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 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: Coroners Statistics 2014 for England and Wales published

The Ministry of Justice has published the latest Coroners Statistics 2014 for England and Wales. The report presents the number of deaths reported to coroners, post-mortem examinations, inquests opened, and inquests concluded.

<https://www.gov.uk/government/statistics/coroners-statistics-2014>

Safety in Custody Statistics England and Wales update to December 2014

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 updates statistics up to the end of December 2014 for England and Wales.

<https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2014-and-annual>

The Safety in Custody Statistics update to March 2015 has been published 30 July 2015.

<https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-march-2015>

Suicide prevention: second annual report published

The Department of Health has published the second annual report on suicide prevention which sets out what local areas can do to prevent suicide and save lives.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

CQC's Mental Health Act Annual Report 2013/14

The Care Quality Commission (CQC) has published their annual report on its role in monitoring the use of the Mental Health Act. The report is based on findings from visits made by CQC's Mental Health Act Commissioners to mental health patients throughout 2013/14.

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/Monitoring-the-MHA-2013-14-Report.pdf>

Safety in Custody Statistics England and Wales 2014

(update to September on assaults & self harm and update to December on deaths in prison custody)

The Ministry of Justice and the National Offender Management Service (NOMS) have published their statistical bulletin on deaths, self harm and assaults in prison custody for England and Wales with an update on figures on assaults and self-harm to the end of September and update on deaths in prison custody to the end of December 2014.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399071/safety-in-custody-to-sept-2014.pdf

Youth Justice Statistics 2013/14 England and Wales

The Ministry of Justice and the Youth Justice Board have published the Youth Justice Statistics 2013/14 for England and Wales. The report contains a section on behaviour management in the secure estate which include an update on the number of incidents of restrictive physical intervention used in the youth secure estate, the number of incidents of self-harm and assaults among young people in custody during 2013/14.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399379/youth-justice-annual-stats-13-14.pdf

Incidents of self harm in immigration detention in 2014

The Home Office has published the number of incidents of self harm and deaths in immigration detention, broken down by immigration removal centres, from July to September 2014.

<https://www.gov.uk/government/publications/incidents-of-self-harm-in-immigration-detention-in-2014>

Fifth annual report of the UK's NPM 2013/14 published

The HM Inspectorate of Prisons has published their fifth annual report of the UK's National Preventative Mechanism (NPM) for 2013-14. NPM members agreed to take the work of the Ministerial Board on Deaths in Custody, progressing common principles of safer restraint, as a basis of their own work. Work and best practices on issues such as the detention of children is shared between members and NPM members working together to comment on UK draft and European legislation.

http://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/07/NPM_AR2013-14_Final_021214_WEB_small.pdf

Learning:**Learning from PPO Investigations - self-inflicted deaths of prisoners 2013/14**

The Prison and Probation Ombudsman has published a document on learning from investigations of self-inflicted deaths of prisoners between April 2013 and March 2014.

<http://www.ppo.gov.uk/ombudsman-publishes-report-on-self-inflicted-deaths-in-prison/>

PPO Learning Lessons Bulletin – New Psychoactive Substances

This report looks at 19 deaths in prison between April 2012 and September 2014, where the prisoner was known, or strongly suspected, to have been using NPS type drugs before their death.

http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB_FII-Issue-9_NPS_Final.pdf

PPO Learning Lessons Bulletin - Segregation

The Prisons and Probation Ombudsman (PPO) has published their latest Learning Lessons bulletin in segregation. The bulletin examines learning from investigations into the self-inflicted deaths of prisoners being held in segregation conditions at the time of death.

<http://www.ppo.gov.uk/wp-content/uploads/2015/06/Learning-Lessons-Bulletin-Segregation-final.pdf>

PPO Learning lessons bulletin - deaths of travellers in prison

The Prisons and Probation Ombudsman (PPO) has published their latest Learning Lessons bulletin in relation to deaths of travellers in prison and use of the ACCT process.

http://www.ppo.gov.uk/wp-content/uploads/2015/01/PPO_LL_B_FII7_Final.pdf#view=FitH

Guidance:

Revised Serious Incident Framework published

NHS England has published their revised Serious Incident Framework supporting learning to prevent reoccurrence. The revised Framework has been developed in collaboration with healthcare providers, commissioners, regulatory and supervisory bodies, patients and families and their representatives, patient safety experts and independent expert advisors for investigation within healthcare.

<http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

EHRC report on Preventing Deaths in Detention of Adults with Mental Health Conditions published

The Equality and Human Rights Commission (EHRC) has published their report into the inquiry on preventing deaths in detention of adults with mental health conditions. The inquiry looked at non-natural deaths between 2010 and 2013 in prisons, police custody and mental health hospitals. They focused on Article 2 (the right to life) and Article 14 (the right to non-discrimination) of the European Convention on Human Rights.

<http://www.equalityhumanrights.com/legal-and-policy/our-legal-work/inquiries-and-assessments/preventing-deaths-detention-adults-mental-health-conditions>

IAP Death in Custody Parliamentary Log latest update

<http://iapdeathsincustody.independent.gov.uk/news/iap-death-in-custody-parliamentary-log/>

The Independent Advisory Panel

Chair

Lord Toby Harris

Lord Harris has been Chair of the IAP since it was established in 2009. He was made a Life Peer in June 1998 and is Chair of the Labour Peers.

Members

Professor Philip Leach

Philip Leach is Professor of Human Rights Law at Middlesex University, a solicitor, and Director of the European Human Rights Advocacy Centre. He has been a member of the Independent Advisory Panel on Deaths in Custody since 2009, leading on its work relating to Article 2-compliant investigations.

Deborah Coles

Deborah Coles is co-director of INQUEST, a charity providing expertise on contentious deaths and their investigation with a particular focus on custodial deaths. Deborah has been a member of the Independent Advisory Panel since 2009, leading its workstream on cross sector learning, equalities and family liaison.

Professor Richard Shepherd

Professor Richard Shepherd is Consultant Forensic Pathologist at the Royal Liverpool Hospital and a leading forensic pathologist in the field of deaths during restraint, with experience of deaths in all forms of custody. Richard has been a member of the Independent Advisory Panel on Deaths in Custody since 2009 and leads the IAP workstream on the use of physical restraint.

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.