



**Minutes of the twenty-first Ministerial Board on Deaths in Custody
1 March 2016
102 Petty France, Ministry of Justice, London**

Attendees:

- | | |
|-------------------------|---|
| Andrew Selous | - Minister for Prisons, Probation and Rehabilitation, (Chair) MoJ |
| Ben Gummer | - Minister for Care Quality, DH |
| | |
| Anne McDonald | - Deputy Director, Offender Health & Mental Health Legislation, DH |
| Deborah Coles | - Co-Director, INQUEST |
| Dame Anne Owers | - Chair of Independent Police Complaints Commission (IPCC) |
| Victoria Bleazard | - Care Quality Commission (CQC) |
| Juliet Lyon | - Prison Reform Trust |
| Miv Elimelech | - Home Office (for Head of Police Integrity and Powers Unit) |
| Kate Lampard | - Chair, Independent Advisory Panel on Deaths in Custody |
| Clive Davis | - For Nick Ephgrave, National Policing Lead, Custody |
| Kate Davies | - NHS England |
| Christine Kelly | - NHS England |
| Fiona Grossick | - NHS England, (by telephone) |
| Lauren Moseley | - NHS England, |
| Mike Durkin | - NHS England, Director of Patient Safety |
| Peter Clarke | - HM Chief Inspector of Prisons |
| Clare Checksfield | - Immigration Enforcement, Home Office |
| Lorraine Atkinson | - Howard League for Penal Reform |
| Digby Griffith | - Director of National Operational Services, NOMS |
| Rachel Atkinson | - Deputy Director Reducing Reoffending, MoJ |
| Cheryl De Freitas | - (for Lord McNally, Chair) Youth Justice Board |
| Nigel Newcomen | - Prisons and Probation Ombudsman |
| Dru Sharpling | - HM Inspectorate of Constabulary |
| Andrew Tweddle | - Coroners' Society for England & Wales |
| Fiona Malcolm | - Executive Director of Operations, Samaritans |
| Katie Kempen | - Chief Exec, Independent Custody Visiting Association |
| Mark Taylor | - Deputy Director, Equality Rights and Decency Group, NOMS |
| Peter Thornton QC | - Chief Coroner |
| Frances Crook | - Howard League |
| Prof. Louis Appleby | - Manchester University |
| Dame Elish Angiolini QC | - Chair, Independent Review of deaths & serious incidents in police custody |
| Kishwar Hyde | - Deputy Head of Secretariat to Ministerial Council (minutes) |
| Angie Hinksman | - Secretariat Support |

Apologies

- | | |
|----------------|---|
| Mike Penning - | Minister for Policing, Crime and Criminal Justice, HO |
|----------------|---|

Agenda Item 1: Welcome and apologies

1. The Chair welcomed everybody to the twenty-first meeting of the Ministerial Board on deaths in custody. He gave a particular welcome to Professor Louis Appleby who was attending for the item on current trends in suicides; Kate Lampard, who was representing the Independent Advisory Panel (IAP) on Deaths in Custody as temporary Chair; Peter Clarke, the new Chief Inspector of Prisons, and Dame Elish Angiolini QC, Chair of the Home Office Independent Review.
2. The Chair also thanked Lord Harris, who had retired in September 2015, for leading the IAP since 2009. His leadership of the Panel and contribution to the Ministerial Board had dramatically improved the Board's understanding on this important subject. The Board were particularly grateful to him for leading the review on Self-Inflicted Deaths of Young People in Custody, the Harris Review.

Agenda Item 2: Approval of minutes of the last meeting and update on action points (MBDC 162 and 163)

3. The minutes of the previous meeting were approved. The Chair reminded Board members that these minutes, and all future minutes of Board meetings, would be published.
4. The Minister noted that all actions were complete or were on the agenda for substantive discussion. Actions he highlighted were:

Action 20/1: DoH to make proposals on how the incidence of police call outs to secure mental health settings can be considered further by the board.

This action was complete. The College of Policing had set up a mental health expert reference group (MHERG) to understand when and to what extent the police service needed to engage in restraint and the use of force specifically during psychiatric emergencies. The Group were drafting a memorandum of understanding which would be circulated to Board members when final.

Action 1: Department of Health to circulate draft to the Board when available.

Action 20/3: Home Office to raise the issue of individuals being held in police cells for their own safety at the PACE strategy board.

The issue was raised at the PACE strategy group on 24 February. The Home Office would provide written feedback for the next meeting.

Action 2: Home Office to present written feedback from the PACE strategy group on individuals held in police cells for their own safety at the next meeting in June 2016.

Action 20/4: Immigration Enforcement to provide a short paper for circulation to board members, including responses to PPO recommendations.

Immigration Enforcement had now written to the PPO in response to their recommendations and would circulate the paper after the meeting.

Action 3: Immigration Enforcement to circulate their response to the PPO to Board members.

Deborah Coles reminded the Board that the action for Civil Legal Aid officials to report back about the status of Legal Aid funding for families at inquests was still outstanding.

Action 4: MOJ to provide an update on the status of Legal Aid funding for families at inquests at the next meeting in June 2016.

Agenda Item 3: Updates from Sectors

3.1 Police

Home Office Independent Review of deaths and serious incidents in police custody – update (MBDC 164)

- 3.1.1 The Independent Review was launched in July 2015. The Chair, Dame Elish Angiolini QC, was appointed in October 2015 and had met family members to discuss their experiences and two Family Listening Days had been arranged. The terms of reference were wide-ranging, covering a range of areas and Dame Elish had met key stakeholders. She was delighted that Inquest and the College of Policing were represented on the Reference Group to assist and advise her during the course of the Review.
- 3.1.2 The review was at the evidence gathering stage; the consultation was online, and a link would be available on the MOJ and Department of Health websites. Board members were encouraged to respond to the consultation.
- 3.1.3 Board members noted that the IPCC thematic report on use of force would be published soon. There was currently no standardised national practice for police forces to record all types of force used; the IPCC had made a number of recommendations designed to improve how force was used, recorded and evaluated. The emerging focus was on mental health, BME and young people.

3.2 Prisons

NOMS update (MBDC 165)

- 3.2.1 NOMS had circulated a written update and reported that the level of self-inflicted deaths was the same as the previous year; natural cause deaths showed a steady incline, due in part to the ageing prison population and the number of homicides had risen – there had been 8 during 2015. The figures on deaths varied dramatically from month to month, with no apparent pattern. Activities to address deaths in custody were continuing:
- NOMS was concentrating on getting this issue to the top of governors' agendas, sending out a series of communications messages, sharing stories of staff making a difference, sending details of particular cases, etc.
 - Processes were only part of the answer; staff needed to be thinking about the issue all the time and engaging in activity in management of risk,
 - The rise in self-inflicted deaths was part of a bigger picture of increasing incidents, including hostage taking and incidents at height. The answer was a targeted set of activities and encouraging good things to happen in a safe environment.

- New psychoactive substances (NPS) remained an issue; NOMS had worked with the Home Office to review policies, trained sniffer dogs, and started testing for NPS, with better testing facilities.
- A new Violence Programme was targeting unacceptable behaviour towards staff and also towards other prisoners.
- The ACCT process had been reviewed.

3.2.2 The Board raised concerns about the need to support prison staff, that the potential to do more remained, and that there was no real follow-up to inquest/coroner concerns. The Chair noted that the MOJ was hoping to make significant progress with the prison reform programme. More research on triggers was needed and also more on how to prepare people to cope with prison. He asked for a discussion at the next meeting on how to capture learning.

Action 5: Sectors to provide information on how they capture learning in their updates for the next meeting in June 2016.

3.2.3 Members also discussed the possibility of greater risk management between the police and prisons. Samaritans had been working with NOMS to produce new material and training for staff, prisoners and families on early days in custody.

Current trends in suicides – Prof Louis Appleby

3.2.4 Professor Appleby had attended the Board in October 2015 to talk about the wider trends in self-inflicted deaths and what bearing this had on the trends for those in custody. He had been asked to return so that the Board could discuss the issues in more detail. Professor Louis Appleby briefed the Board that:

- The rise in suicides in prison was comparable to the rise in the general population in some respects. However there were differences: suicides in the general population were not as high, they took place across a wider age range, and young men in the general population were not a high risk of suicide, while those in prison were.
- Possible explanations for the rise in self-inflicted deaths in prisons were that prisoners were a high risk group; prison experience and the prison environment impacted on the individual's state of mind; staff turnover and lack of continuity in forming relationships was a factor. When tackling suicides, the message from the top was important, as was a culture of learning, and the need to understand how staff behaved in risk situations and why they failed to do what they had been trained to do in those situations. There was a need to reduce the impact of prisons, including unnecessary transfers and lack of activity. Protective factors needed to be understood and measured, and there was a need for an independent look at antecedents.

3.2.5 NOMS agreed that the staffing issue was very complex as there were prisons where there were fewer staff but no rise in the rate of deaths. It was noted that there had been a previous spike in the number of self-inflicted deaths in 2007/8 which coincided with a spike in the prison population. The last two years had also seen a higher custodial population.

3.3 Health (MBDC 166)

- 3.3.1 A paper had been circulated prior to the meeting. In December 2015, the Health Secretary had asked the Care Quality Commission (CQC) to undertake a review into the investigation of deaths in a sample of all types of NHS trust (acute, mental health and community trusts) in different parts of the country. As part of this review, the CQC would assess whether opportunities for prevention of death had been missed, for example by late diagnosis of physical health problems. The CQC would be engaging with NHS trusts, and with partners in the national healthcare system, to define best practice and develop a system-level intervention. Early findings from the report would be published in the near future. The CQC would liaise with INQUEST about the possibility of families contributing to the review.
- 3.3.2 The Equality and Human Rights Commission had held a workshop in February 2016, facilitated by Professor Appleby, to look at ways to improve data on deaths of detained patients by developing a cross agency action plan. The CQC had been asked to look at the quality of recording of deaths by providers and NHS England took away work on who would carry out investigations and how, including looking at independence and capturing learning.
- 3.3.3 The Minister noted that NHS England had made big strides in the last couple of years, learning cultures were beginning to take root and have an impact, and there were significant drops in the number of deaths. It was important to create safe spaces for staff to talk about failures without fear of censure. Discussion took place on how safe places could be created and trust between patients and staff built.

3.4 Immigration Enforcement (MBDC 167)

- 3.4.1 A paper was circulated prior to the meeting. Since 2010 there had been 13 deaths in immigration detention – 12 men and one woman. There were two deaths in 2015 (one self-inflicted and one from natural causes). Due to the low numbers it was difficult to identify any trends.
- 3.4.2 Home Office Immigration Enforcement (IE) had a network of commissioned services and had been working with both NOMS and NHS England to understand the population and the risks better. Uncertainty was a big issue and in that respect, this was more like the remand population.

Agenda Item 4: Updates from members

4.1 Harris Review and Prison Reform update (MBDC 168)

- 4.1.1 The MOJ presented an update on the Government's response to the Harris Review which had been published since the last meeting. The general thrust of the Review recommendations was that leadership was critical, as was purposeful activity and developing relationships between staff and prisoners. Much consideration had been given to the recommendation for a care and rehabilitation officer but MOJ had decided that it was important that all staff were focussed on building relationships. The Review conclusion would be built into the Reform Programme, in particular through empowering prison governors. The Chair noted that 70% of the recommendations from the review had been agreed and the reform programme was concentrating on autonomy,

improved education, renewed work, and an increased focus on prisoners' families.

- 4.1.2 Concerns were raised as to the consideration of the Review by the Ministerial Board and that Lord Harris had not had the opportunity to brief the Board on the Reviews' recommendations. The Chair therefore requested that Lord Harris be invited to the next meeting and that MOJ give an update on prison reform.

Action 6: Invite Lord Harris to the next Ministerial Board for a discussion of the Harris Review recommendations.

4.2 Chief Coroner proposal initiative for 2016 (MBDC 169)

- 4.2.1 The Chief Coroner had submitted a paper with a set of proposals for the Board to consider. He suggested that the Ministerial Board had become an information sharing committee and proposed that all attending organisations should draw up a list of their top five priorities that they thought the Board should take forward. It was agreed that members should send their contributions to the Secretariat; and that these would then be discussed by co-sponsors prior to the next meeting.

Action 7: Board Members to send their list of items for the Board to take forward to the Secretariat.

4.3 Howard League publication: *the cost of suicide* (MBDC 170)

- 4.3.1 The Howard League paper on the cost of suicide was published in February 2016. The Howard League and Centre for Mental Health are investigating how to introduce best practice from the community to prevent prison suicides and will publish a series of reports. The Howard League recommended that the MOJ should consider cost of suicides in prisons in England and Wales as experience from the transport industry had shown that significant investment in prevention could be a cost saver. Members noted that while the report was helpful, it would be extremely difficult to calculate the financial costs of suicide in prison. Moreover, action should be taken to address such deaths regardless of how much or little the costs could be said to be.

Agenda Item 5: Independent Advisory Panel Update

- 5.1 Kate Lampard had taken up post as temporary Chair of the Independent Advisory Panel in November 2015. She had been requested by the Secretary of State for Justice to undertake a stocktake of the IAP in lieu of the Cabinet Office Triennial Review which had been pushed back. Kate had had several meetings with relevant persons and was still in the early stages of discussion; a full paper on the subject would follow in due course but emerging thinking was:

- That there needed to be greater cross-over between the IAP and the Ministerial Board
- That the structure of both Board and Panel needed to be different to the current model to allow delivery on their remits
- There ought to be closer working between the panel and investigative bodies

- That the panel should have a smaller remit but greater involvement in each work stream.

5.2 In the meantime, the current Panel continued to conduct its business as usual and were due to meet the following week. The Chair asked for an update on panel work stream for the next Board.

Action 8: IAP to provide an update on its work programme at the next Board.

The recruitment campaign for the new permanent IAP Chair was proceeding well and interviews would be held after the Easter break.

Agenda Item 6: Any Other Business

PPO publications on prisoner mental health and early days

6.1 The PPO had recently published two documents: a *Thematic on prisoner mental health* in January 2016 and a *Bulletin on early days and weeks* in February 2016. The PPO explained that the reports were his attempt to provide a learning agenda and the he hoped that they were useful to members.

6.2 The Chair thanked the Ombudsman and asked for the reports to be tabled in full for the next meeting.

Action 9: Discussion of PPO publications on prisoner mental health and early days to be tabled for next Board.

Agenda Item 7: Date of next Ministerial Board on Deaths in Custody

7.1 **The next meeting would be held on 14 June 2016** at Richmond House, Whitehall. It was due to be chaired by the Minister for Care Quality, Department of Health.