Minutes of the twenty-eighth meeting of the Ministerial Board on Deaths in Custody
27 February 2019
Home Office, London

Attendees:

Rt Hon Nick Hurd MP	- Minister of State for Policing and the Fire Service, Home Office (Chair)
Rory Stewart OBE MP	- Minister of State for Prisons and Probation, MoJ
Nick Poyntz	- Deputy Director, Prison Safety and Security, Ministry of Justice
Fran Oram	- Director for Mental Health, Dementia and Disabilities, DHSC
Frances Hardy	- Head of Risk and Assurance, Immigration Enforcement
Heidi Pearson	- Deputy Head of Police Powers Unit, Home Office
Sue McAllister	- Prisons and Probation Ombudsman
Deborah Coles	- Director, INQUEST
Juliet Lyon	- Chair, Independent Advisory Panel on Deaths in Custody
ACC Nev Kemp	- NPCC Custody Portfolio Lead
Dame Anne Owers	- National Chair of Independent Monitoring Boards
Katie Kempen	- Chief Executive, Independent Custody Visiting Association
Frances Crook	- Chief Executive, Howard League for Penal Reform
Peter Clarke	- HM Chief Inspector of Prisons
Peter Dawson	- Director, Prison Reform Trust
Colin Allars	- Chief Executive, Youth Justice Board
Britte Van Tiem	- Samaritans
Phil Copple	- Director General, Prisons
Michael Lockwood	- Director General, Independent Office for Police Conduct
Kate Davies	- Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England
DCS John Carroll	- Deputy Director, Protecting Vulnerable People, HMICFRS
Andy Herd	- Mental Health Policy, Department of Health
Nick Goodwin	- Director, Access to Justice, Ministry of Justice
Andrew Fraser	- Head of Secretariat to Ministerial Council,
Kishwar Hyde	- Deputy Head of Secretariat to Ministerial Council (minutes),

Apologies

Wendy Williams	- HM Inspectorate of Constabulary and Fire and Rescue Services
HHJ Mark Lucraft QC	- Chief Coroner
Charlie Taylor	- Chair, Youth Justice Board
Michael Spurr	- CEO, HMPPS

Item 1: Welcome, apologies and minutes

Welcome

1.1 The Chair welcomed members of the Ministerial Board. Apologies were noted from Jackie Doyle-Price MP (Under Secretary of State, Department of Health and Social Care), Michael Spurr, Wendy Williams HMI, HHJ Mark Lucraft QC, and Charlie Taylor.

1.2 The Chair explained that the Government's Review of Legal Aid for Inquests was published on 7 February, setting out further work to make inquests less adversarial and more bereaved family friendly. The report sets out a view on legal aid for inquests, stating it wants to explore further options for the funding of legal support at inquests where the state has state-funded representation.

1.3 The Chair invited Deborah Coles to give her views on the publication of the Review. Deborah stated that INQUEST had serious concerns about the conduct and outcome of the review and was bitterly disappointed and frustrated that it failed to take into account the overwhelming evidence about the lack of a level playing field for bereaved people at inquests into deaths in custody and detention. INQUEST cooperated with the review, facilitated engagement from families and our lawyers group and were led to believe that there would be reforms made. She said that she felt this decision is a crushing betrayal of those families who invested in the review, believing this process would once and for all bring about the much-needed meaningful change. Deborah said that she did not consider that the views of the families had been taken into account nor the recommendations of the various reviews exploring these issues which have repeated the urgent need for funding reform. She reiterated that public authorities are routinely instructed at these inquests paid for from the public purse and the unfair and distressing application process families had to go through when grieving. She said this was about access to justice and a level playing field, the important role of family representation in uncovering systemic failings that if rectified could help protect lives in the future and that non-means tested legal aid was necessary. Deborah said she was meeting Minister Frazer on 7 March and was keen to discuss the points raised by families further.

1.4 The IOPC supported the points made by Inquest and had found engagement with families to be an important means of improving the service provided by the IOPC. Supporting the families to fully engage in the inquest process is an important part of ensuring that the correct lessons are identified.

1.5 MOJ explained that Minister Frazer would have attended the Ministerial Board but it clashed with the APPG on Legal Aid. MOJ was very grateful for the evidence provided by all respondents. Nick Goodwin said that important changes were being made to the system and legal aid for inquests continued to be available through the Exceptional Case Funding (ECF) scheme. Nick

also noted that the ECF guidance and the means testing element were being improved as there was agreement that the process was too complicated. Nick explained that there is a genuine effort across Whitehall to improve the legal aid system to support families.

1.6 Juliet Lyon asked if the means testing system had become so complicated that it was now costlier than providing legal aid. Nick noted that the Director of the Legal Aid Agency had the discretion to waive the means test, and this option was also being looked at further.

1.7 Minister Stewart said that the financial implications for the departments for providing legal aid for all inquests could be as much as £80 million. He noted that, for death-in-custody inquests, the figure would be significantly less – particularly as these inquests often receive funding anyway. Deborah said that the means testing process was both complicated and extremely difficult for families when they were going through a deeply emotional experience at the same time.

1.8 The discussion concluded with Minister Stewart noting that he had spoken to Minister Frazer and can confirm that she was happy to attend the next Board to discuss this issue further.
Action 1: Minister Frazer to be invited to next Board meeting

Minutes of the last meeting
1.9 The minutes of the twenty-seventh meeting in October 2018 had been approved by the departmental co-sponsors and circulated prior to this meeting. The Chair noted that the minutes have been agreed, but invited members to raise any issues of accuracy with the Secretariat.

Item 2: Ministerial Board Year 2 work programme

2.1 Andrew Fraser introduced the work programme stating that it had been updated since the last Board meeting but would still look largely familiar to Board members from previous meetings. The work programme continued to be centred around the 5 themes:

a. **Healthcare in police custody** - Reduce the risk of a death in police custody occurring
b. **Support for families** - If a death in custody occurs, ensure better support for families
c. **Inquests and Legal Aid** - If a death in custody occurs, ensure families are supported through the inquest process
d. **Investigations** - Ensure investigations and inquests are timely
e. **Improve performance and accountability** - Ensure lessons are learnt from deaths and organisations are held to account

2.2 Andrew noted that the significant changes made to the Y2 work programme were:

- **Healthcare in police custody** - A workstream was added to reflect potential work deriving from the recent review of the Mental Health Act that colleagues at DHSC may want to recommend.

- **Support for families** - The leaflet for bereaved families following a police death – developed collaboratively by Inquest, the Home Office, NPCC, Ministry of Justice and Chief Coroner's office – was published before Christmas, and was now available for use. A workstream was added to monitor the use of the leaflet, and take on board any feedback before considering whether a similar document could be extended to other sectors.

- **Support for families** - A workstream was added to cover some scoping work to consider the possibility of providing bereavement counselling to families.

- **Investigations** – The IOPC had brought a paper to the Board outlining their efforts to improve the timeliness of their investigations. One of the main points in the paper was that the IOPC was only one actor in a complex investigation process so a new workstream was added to reflect the multi-agency efforts to reduce investigation timescales across the system.

- **Improve performance and accountability** - Following the discussion at the last Board regarding greater interaction with bereaved families after the inquest process, a new workstream was added to reflect this in the learning section towards the end of the work programme.

2.3 Minister Stewart noted that the work programme currently had a lot of focus on supporting families, and asked what more the Board could do to prevent deaths. In his area of responsibility, he was concerned about the implementation of ACCT procedures and impact of childhood trauma, for example. He also highlighted the importance of focussing on training, and suggested looking at how prisons can appropriately support IPP prisoners.

2.4 Board members made a number of recommendations for adding to the work programme including:

- Frances Crook said that preventing deaths must be the main focus of the Board. There had been a recent rise in non-natural deaths, and of those from natural deaths, and there should be more information being shared regarding what is being done within HMPPS to stop such deaths.
- The IOPC did not want to see the same types of death, and same issues being raised year after year. The IOPC was actively focussing

on prevention and what could be done differently in future cases, including sharing case studies to help the police do this.

- Kate Davies noted the important middle-ground between preventing deaths and supporting families. This concerns the identification of areas and establishments of risk, as well as highlighting those that present examples of good practice. There should be more work carried out on identifying risk better.
- The PPO produces hundreds of reports each year and the Ombudsman would like them to have more impact. The PPO are working with HMPPS to discuss some of the barriers to impact, and are also keen to think further about how they target their resources proportionately.
- IMB agreed saying that the work programme should contain more emphasis on prisons, and some of this should concern governance of procedures given the health profile of the population.
- Deborah Coles said that Mental health and deaths in mental health hospitals also need more attention, and asked for this to be a substantive item on the next Board agenda.
  Action 2: Mental Health to be on the agenda at June Board meeting

- More focus on accountability; this could include PFDs and how the different sectors address the learning from inquests. There is a workstream in the work programme concerning PFDs and DHSC would include these points in the existing workstream.
- DHSC noted that target dates should be included for all workstreams.
  Action 3: Secretariat to ensure that target dates are added to all workstreams in the work programme.
- Several members of the Board suggested taking forward more work on people as they leave custody or mental health hospitals as there is a significant number of suicides among this group each year. The PPO was keen to undertake more investigations on deaths after release from custody. Juliet Lyon pointed to the recent research undertaken on this issue by Dr Nicola Padfield at Cambridge University, and explained that the IAP also remained interested in this issue.
- PRT noted that soon there would be more recalled IPP prisoners than those serving original IPP sentences. The PRT is taking forward two bits of work – firstly to talk to IPP prisoners, and secondly to talk to their families.
- Deborah Coles also said that she would like to see more focus on accountability. This could include PFDs and how the different sectors address the learning from inquests. DHSC noted that there is a workstream in the work programme concerning PFDs and would take it forward in light of Deborah's comments.

- Phil Copple reminded members to take account of the wider context – beyond training and compliance with procedures. There was a need to look at the trends of rise and falls in deaths over the last decade. Some of the themes coming out of prisons were: approximately 66% of those who take their lives in prison were not on an open ACCT at the time of their death – and this is a figure largely consistent across the developed world. A whole institution approach was needed - time out of cell, strong relationships in and outside of prisons. These wider issues pointed to the need for a positive culture across the whole system.

2.5 Minister Stewart said that he was concerned that deaths appear to be rising again despite the recent securing of more funding. PC agreed that the issue is critical and said that it is very difficult to point to precise reasons for the difference in the number of deaths each year. Statistically speaking, a degree of random volatility is likely each year, and there will be a time lag between investment and the benefits from it. The significant impact of the increase in drugs in prisons over the last decade was also noted.

2.6 The Chair thanked members for their input and summarised their views on the work programme as:

- More equal balance between prevention and support for families
- More work on prison and mental health sectors
- More focus on using PFDs effectively, and learning from post-custody deaths.

2.7 Andrew Fraser confirmed that the secretariat will revise the work programme and circulate it to Board members before the next Board meeting.

Item 3: IAP 2019 work programme

3.1 Juliet Lyon introduced the IAP's work programme and explained the strategic principles that the IAP will abide by while undertaking their work. She noted that the IAP has welcomed the close relationship it has developed with the Samaritans, Inside Time, Prison Radio and Board members and will continue to utilise these in their work. Juliet was keen to receive feedback from Board members on the IAP's work programme. She summarised some of the main items on the work programme including the work to support the Home Office on implementing Stephen Shaw's recommendations on the immigration estate, work to help HMPPS/MoJ refresh the ACCT procedures, and the IAP's involvement in the alternatives to restraint workstream.

3.2 Juliet explained that the IAP is also currently finalising a briefing pack on the physical and mental health impacts on IPP sentences. Minister Stewart said that he would welcome concrete and specific recommendations

on how prisons could better support IPP prisoners and asked for day-to-day advice on how to manage and support these prisoners better.

3.3 IMB supported the focus on IPP prisoners, and highlighted the good practice at HMP Warren Hill identified in a recent report. A further area of risk was at release where, without significant support, there was a genuine risk of recall and return to prison. Juliet raised the IAP's idea of a safety impact assessment to ensure that any proposed policy change takes into account its impact on safety. The Minister welcomed the idea but said that he preferred a more multi-dimensional tool to aid Governors when deciding on changes to their establishment. Juliet noted that the assessment is designed for advice going to Ministers, and PRT agreed that maintaining a focus on safety is essential for all policy-making – not just operational matters.

3.4 DHSC said that they would prefer the final item in the IAP's work programme concerning recording of deaths and seeking independent investigations for deaths in mental health hospitals to be split into two points:

> *Review how deaths in custody and detention are recorded and collated* ***and*** ***[split here]*** *seek to secure independent investigation of all such deaths.*

Action 4: IAP to revise their work programme as relevant and publish.

Item 4: Accountability to/learning from bereaved families (workstream 5b.2) – introductory paper from the IAP

4.1 Juliet Lyon introduced the main points and recommendations of the paper and explained how important it is to fully engage with families following a death in custody – both for their sake, and to improve the learning from the death.

4.2 NK supported the paper, and agreed that the appropriate level appears to be the Chief Officer in each force. He would welcome more thought on which deaths this idea should cover – for example, those in custody, or suicides after police custody as well. FH said they speak to families after a death, but agreed that there could be greater engagement after the conclusion of the inquest.

4.3 Other members stated that the work needed to identify what the tangible benefits might be, and to take into account all deaths, and acknowledge the recently published end of life care patient charter. Establishing the mechanism involved for this level of engagement needed to be undertaken with families as they were likely to want different things to Board members, and to each other. Michael Lockwood noted that there are a few important, but simple, things that needed to take place to ensure this type of initiative succeeds - families needed a single point of contact; there need to

be clear principles for good practice and services need to be better at going back to families to explain what is being done.

4.4 Minister Stewart said that he would like this work to be placed in the context of how the state engages with a wide range of families – including victims, accidents and deaths in custody.

Item 5: Departmental updates

Health

5.1 Andrew Herd summarised some of the key points from the DHSC update paper, including the recent publication of the NHS long-term plan. He said that the Government is currently considering its response to the Review of the Mental Health Act and that the department is taking forward work on the Crisis Care Concordat review.

Immigration Enforcement

5.2 Frances Hardy stated that the immigration estate typically experiences few deaths (there were none in 2017). The Home Office is taking forward work with the IAP on Stephen Shaw's review and how the department releases data on deaths in immigration detention.

Prisons

5.3 Phil Copple explained that the HMPPS update notes the increase in self-inflicted deaths and reduction in natural cause deaths, but acknowledged that the number of deaths awaiting further information (AFI) means that the numbers in the former two categories could change. He outlined some of the key factors relating to self-inflicted deaths: 60% occur in local prisons, some are clusters of suicides, and 33 took place in 9 establishments.

5.4 Work currently being undertaken in HMPPS:

- the ACCT pilot is underway, HMPPS are reviewing the QA process and more training on ACCT continues to be delivered.
- considerable support continues to be provided to the 16 prisons identified to be of concern.
- the Health and Safety Executive is also looking into a death at HMP Lincoln.
- HMPPS were working with ONS to standardize their statistics

5.5 Members had asked about PAVA so Phil clarified the following about its use in prisons:

- PAVA is primarily for reducing the severity of violence in prisons and not about reducing deaths

- There had been some recent violent incidents that, had PAVA been available, it may have reduced the level of serious assault on staff and prisoners in those instances
- The policy is clear that PAVA should not be used towards those that are self-harming.
- PAVA should only be used as a last resort and to reduce the severity of violence
- Strong governance locally and nationally will be in place to monitor its usage

Police

5.6 Heidi Pearson reported that there were 23 deaths in police custody in 2017/18 (up from 14 in the previous period), none of which were self-inflicted. She noted that the focus of the Home Office continues to be implementing the recommendations from the Angiolini review.

Item 6: Any other business

There was no other business

Date of next meeting: 6 June 2019, 3-5pm, DHSC