HM Government

Ministerial Board on Deaths in Custody

Meeting minutes

30 November 2021

Attendees

Gillian Keegan MP, Minister of State for Care and Mental Health, Department of Health and Social Care (DHSC) - **CHAIR**

Victoria Atkins MP, Minister of State, Ministry of Justice (MoJ)

Kit Malthouse MP, Minister of State for Crime and Policing, Home Office, MoJ

Junior Johnson (JJ), Deputy Director, Scrutiny, Performance and Engagement, MoJ (lead co-sponsor)

Rachel Pascual (RP), Deputy Director, Prison Safety, Security and Operational Policy, MoJ

Sally Grocott (SG), Deputy Head of Scrutiny, Performance and Engagement, MoJ

Anna Lacey (AL), Deputy Director, Female Offenders and Offender Health Policy, MoJ

Kathy Smethurst (KS), Deputy Director, Mental Health and Offender Health, DHSC

Richard Jolley (RJ), Deputy Head, Police Powers Unit, HO

Phil Riley (PR), Head of Detention and Escorting Services, Immigration Enforcement, HO

Frances Hardy (FH), Detention and Escorting Services, Immigration Enforcement, HO

Phil Copple (PC), Director General Prisons, HM Prison and Probation Service (HMPPS)

Kate Davies (KD), Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England (NHSE)

Fiona Grossick (FG), National Clinical Quality Lead, NHSE

Cathy Edwards (CE), Clinical Programmes Director, NHSE and NHS Improvement

Jemima Burnage (JB), Deputy Chief Inspector of Hospitals and Lead for Mental Health, Care Quality Commission (CQC)

Keith Fraser (KF), Chair, Youth Justice Board

Juliet Lyon CBE (JL), Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)

Professor Jenny Shaw (JS), IAPDC

John Wadham (JW), IAPDC

Justin Russell (JR), HM Chief Inspector of Probation

Charlie Taylor (CT), HM Chief Inspector of Prisons

Sir Thomas Winsor (TW), Chief Inspector of Constabulary and Fire and Rescue Services (HMICFRS)

Norma Collicott (NC), HMICFRS *(in place of Tony Hirst)*

Sue McAllister (SM), Prisons and Probation Ombudsman (PPO)

HHJ Thomas Teague QC (TT), Chief Coroner of England and Wales

Peter Dawson (PD), Director, Prison Reform Trust

Andrea Coomber (AC), Chief Executive, Howard League for Penal Reform

Deborah Coles (DC), Executive Director, INQUEST

Julie Waltham (JW), Head of Policy, Public Affairs and Campaigns, Samaritans *(in place of Jacqui Morrissey)*.

Ashley Bertie (AB), Chief Executive, Independent Custody Visitors Association (ICVA)

ACC Nev Kemp, Police Lead (Custody), National Police Chiefs' Council (NPCC)

Apologies

Professor Seena Fazel, IAPDC

John Thornhill, Chair, Lay Observers' National Council (LO)

Dame Anne Owers, National Chair, Independent Monitoring Boards (IMBs)

Michael Lockwood, Director General, Independent Office for Police Conduct (IOPC)

Item 1: Welcome, apologies, actions and minutes

1.1 The **CHAIR** welcomed everyone to the meeting. Minutes from the last meeting in June had been approved and published[1] and were circulated prior to the meeting. The **CHAIR** asked that comments about the minutes or actions be directed to the secretariat.

1.2 **The CHAIR** welcomed new members of the Board:

- **Jemima Burnage**, Deputy Chief Inspector of Hospitals and Lead for Mental Health, Care Quality Commission
- **Ashley Bertie**, Chief Executive, Independent Custody Visitors Association
- **Andrea Coomber**, Chief Executive, Howard League for Penal Reform
- **Cathy Edwards**, Clinical Programmes Director, NHS England and NHS Improvement.

1.3 **The CHAIR** apologised for the altered meeting time and explained that the order of the pre-circulated agenda had changed as a result.

Item 2: Healthcare and prison response to deaths of babies in prison

2.1 **SM** gave a brief background to the PPO's investigations into the deaths of two babies in prison. The PPO investigated the death of Baby A at HMP Bronzefield, which occurred in 2019, and published the report in September 2021. The report into the death of Baby B at HMP Styal, which occurred in 2020, is due to be published by the end of the year.

2.2 The PPO's Baby A report[2] contained 18 recommendations for MoJ, HMPPS, NHS, and Sodexo, and included the need for a midwifery model tailored to women in prison and trauma-informed care. MoJ and HMPPS have worked closely with NHS England & Improvement and Sodexo to produce an action plan[3] outlining their response to the report's recommendations, though much of it is in the early stages. Issues were raised in the report about officers on duty who did not respond to the cell call bell. **SM** noted that it was disappointing that there was no requirement for the prison to provide information on any disciplinary action taken. The model for monitoring contract compliance in the prison was also found to be not fit for purpose.

2.3 In response, **KD** explained that NHSE were already undertaking a review of maternal and perinatal services across the English women's estate. They had been working closely with Sodexo at HMP Bronzefield and had increased the commissioning and support of primary care, midwifery, maternal and perinatal care, and were looking at developing

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[1] Minutes, Ministerial Board on Deaths in Custody, 9 June 2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037356/MBDC-minutes-09062021.pdf.

[2] PPO, *Independent investigation into the death of Baby A at HMP Bronzefield on 27 September 2019*, September 2021. Available at: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/F4055-19-Death-of-Baby-A-Bronzefield-26-09-2019-NC-Under-18-0.pdf.

[3] HMPPS, *Action Plan, Death of Baby A at HMP Bronzefield*, May 2021. Available at: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/F4055-19-Death-of-Baby-A-Bronzefield-26-09-2019-NC-Under-18-0-AP.pdf.

training in recognising the early signs of labour. The independently chaired National Women's Prison Health and Social Care Review Group are reviewing a range of services with the aim of improving the health and wellbeing of women in prison, and increasing the quantity and quality of care afforded to women in prison and on release. **KD** said that there were important lessons to learn about the whole pathway of women in prison, including around short sentences, pregnancy, and babies. **FG** added that NHSE were working closely with HMPPS and other partners to review and enact the recommendations from the deaths.

2.4 **PC** explained that HMPPS were seeking to embed learning from the failings in both cases, at a local level with health providers and commissioners, but also at a national level. Steps taken included:

- publishing a new policy on 'Pregnancy, Mother and Baby Units and Maternal Separation from Children up to the Age of Two in Women's Prisons'[4];
- improving the support for women who are not engaging in perinatal services;
- guidance for staff to identify signs of labour in the event of unexpected labour, and improving emergency response in the event of an unexpected birth;
- access to pregnancy advice services; and
- investing in more Mother and Baby Liaison Officers across the women's estate.

2.5 **PC** stated that HMPPS are taking a systemic approach to compliance and embedding learning. HMP Bronzefield is one of a few private prisons where legacy commissioning arrangements still exist but HMPPS are working to ensure they are mainstreamed with NHS commissioning and brought into line with the rest of the estate.

[Secretary's note: Ministers left the meeting temporarily]

2.6 **DC** raised three points she wanted to ask Ministers:

- The appropriateness of prisons for pregnant women.
- The culture operating at HMP Bronzefield where women were branded as having a bad attitude and being difficult.
- The failure of staff to respond to cell bells. A recent inspection report on HMP Chelmsford had also flagged this issue.

2.7 **PC** recognised the scale of the challenge around culture which HMPPS were trying to address through good leadership. The issue of cell bells could be a reflection of these challenges, but was also related to ensuring the right systems are in place.

2.8 **KD** thought that focus needed to be on well-being and how that shift in focus could be made.

2.9 **SM** explained that the publication of the second report will provide more information on areas to focus on and where to direct work. Unfortunately, the PPO has no role in following

[4] HMPPS, *Pregnancy, Mother and Baby Units (MBUs), and Maternal Separation from Children up to the Age of Two in Women's Prisons*, October 2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023428/mbu-pf.pdf.

up on recommendations but has held good conversations with HMPPS and others at quarterly meetings to pick up on systemic issues. The PPO have also now incorporated the investigation of deaths of babies in prison into their revised Terms of Reference.

2.10 **JJ** thanked everyone for the progress already made and requested a further update at the next Board meeting.

Action 1: NHS & HMPPS to provide a further update at the next MBDC meeting against progress to deliver PPO recommendations in response to the deaths of Baby A and Baby B.

Action 2: MoJ to write to Deborah Coles about the appropriateness of prisons for women, and broader issues that the baby deaths raise regarding staff culture and response to cell bells.

Item 3: Joint thematic response of the Criminal Justice System (CJS) response to mental health needs and disorders

3.1 **JR** explained that the joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders[5] was published on 17 November. This was the first time the issues faced by people with a mental health problem going through the whole criminal justice system had been looked at since the Bradley Report[6] 12 years ago. The inspectorates visited six areas, interviewed over 500 people and looked at 300 cases between April and May.

3.2 **JR** summarised key findings from the report, which found high levels of mental ill health in the criminal justice population at every stage. The journey through the CJS worsened people's mental health, impacting their ability to participate in the process and to understand what was happening to them. The report concludes that the system for sharing information between agencies is broken. The inspectorates found there are no prompts in the system to share information, and there is a fundamental misunderstanding of the Data Protection Act meaning people felt that they could not share information even when it would have been helpful. Even when assessments are done and diagnoses made, gaps remain in the treatment available and the number of available mental health beds.

3.3 On policing, some improvements had been made since the Bradley Report, particularly around police handling of people with mental ill health. The national roll out of Liaison and Diversion (L&D) has improved police access to mental health assessment expertise and secure hospital beds. However, there continued to be variation between different police force areas and in the referrals made. The report identifies poor information exchange between the police and the Crown Prosecution Service and the need for better training of police officers in relation to mental health issues.

3.4 **CT** highlighted three major concerns regarding prisons:

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[5] HMI Probation, *A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders*, November 2021. Available at: https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/11/Mental-health-joint-thematic-report.pdf.

[6] The Bradley Report, Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, April 2009. The Bradley Report: Executive Summary (choiceforum.org)

- Prisons being used as a place of safety, which is particularly prevalent in the women's estate. HMPPS have written to the prisons minister recommending that MoJ collects data on this.
- Unacceptable waiting times for transfers to secure mental health hospitals.
- The impact of Covid-19 on mental health services available in prisons and the cessation of face-to-face appointments.

3.5 **CT** stated that mental health assessments were generally very good, though concerns remain about people leaving prisons and the services available to them.

3.6 **JR** said that the report made 22 recommendations, including the need to:

- Develop multi-agency understanding of how information on someone's mental health can be shared at local and national levels. Assessments from L&D are not being sent to CPS or defence lawyers and there was no method of CPS recording mental health illness.
- Improve arrangements for the commissioning and monitoring of psychiatric assessments and reporting.
- End the inappropriate use of prison as a place of safety and ensure that alternatives to prison are available for sentencers.
- Provide a better system to move people quickly from prisons to mental health hospitals.

[*Secretary's note: Ministers returned to meeting]*

3.7 **JL** stated that the IAPDC had found that community sentences with Mental Health Treatment Requirements (MHTRs) were only used in fewer than 1% of disposals. Magistrates had told the panel that they either did not know about them or that they were not available in their area. **JL** wanted to see these being prioritised and rolled out quicker across England. **JR** welcomed the roll out program and was aware that coverage was increasing.

3.8 **KD** stated that NHSE will be increasing MHTR capacity to deliver a more organised programme of work. There had been problems putting in place a joined-up approach to funding treatment requirements in the same way as for L&D services, and there is an increased need for more combined orders involving drug and alcohol treatment.

Item 4: Key workplan updates

4.1 **JJ** explained that since the last meeting the Board had agreed a 12 month workplan built around the three objectives of mental health and substance misuse; embedding learning; and COVID-19 and physical health. The workplan would be considered alongside the themes of the evidence base, race and the impact of disproportionality, and the perspectives of people with lived experience as well as bereaved families. The workplan was split into 18 overarching sections, with 50 specific projects.

4.2 Some work highlights included:

- Improvements to data collection and transparency, including collation of data on restraint-related policing deaths over the last 10 years.
- HMPPS aligning their approach to the cross-government drugs strategy as it relates to substance misuse deaths.
- The imminent publication of the statutory guidance and response to the consultation for the Mental Health Units (Use of Force) Act, with most provisions coming into force early next year.

4.3 Further sessions will be convened with the Board's membership to take forward some of the work strands. As part of the revisions to the Board, a new gov.uk page[7] is now live and hosts the Board's Terms of Reference and minutes of meetings. Updates on progress against the workplan will be provided ahead of the next meeting.

4.4 **PD** welcomed the update on the Safety Impact Assessment in the workplan paper and asked whether such an assessment had been undertaken to consider the impact of the increase in the number of prisoners expected from courts. **PC** responded that the assessment was not being used to assess those emerging pressures but could be considered for supply planning in the future.

Action 3: HMPPS to consider how the Safety Impact Assessment can be incorporated into supply planning for future prison population pressures.

Item 5: Independent Advisory Panel on Deaths in Custody (IAPDC) update

5.1 **JL** summarised key panel work since the last meeting:

- A new statistical report[8] outlining rates of deaths by custodial settings between 2016 and 2019 had just been published. The report showed that a fifth of all deaths were self-inflicted. While the highest number of deaths occurred in prison, the highest rate of deaths was among those detained under the Mental Health Act. There were some troubling gaps in the data, particularly concerning deaths in secure hospitals which the panel hope can be resolved ahead of the next bulletin.

- A police leadership initiative to communicate a zero-tolerance approach to deaths in police custody started earlier this year, in collaboration with the policing minister. The panel had sent a joint letter with the minister asking the Police and Crime Commissioners (PCCs) for examples of good practice which could be shared with other areas. The 23 initial responses included detailed reference to L&D services, street triage, and work with mental health first responders. A second joint letter had just been sent to PCCs and further responses received. The panel will publish a full report and work with colleagues to progress recommendations in the new year.

[7] Ministerial Board on Deaths in Custody website. Available at: https://www.gov.uk/government/groups/ministerial-board-on-deaths-in-custody.

[8] IAPDC, *Statistical analysis of recorded deaths in custody between 2016 and 2019*, November 2021. Available at: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/61a10d3c3b53df1223948194/1637944636899/IAPDC+statistical+analysis+report+-+November+2021.pdf.

- The panel are embarking on work with the Chief Coroner to improve the impact of coroner written Prevention of Future Deaths reports (PFDs). The panel have taken a sample of PFDs across custodial sectors and assessed their quality, distribution and the take-up of matters of concern raised. A series of roundtables with coroners will help inform final recommendations.

5.2 **TT** stated that he was fully supportive of the PFDs project, and ready to engage with the roundtable discussions, which will need to be carefully managed to ensure they do not impact judicial independence.

5.3 **JL** raised the issue of the new Covid-19 variant, the danger it may pose to people in prison and the risk, according to SAGE advice, of prisons becoming 'reservoirs of infection' for the wider community. It was important to learn from previous rounds of the pandemic. The panel would be writing to the Board chairs highlighting concerns and offering advice on how to protect lives.

5.4 In response, **PC** explained that the prison service had a framework for managing the virus which it operated within. One of its principles is around how to strike a balance between safety and wellbeing. Decisions will be based on best evidence and advice received in the next few weeks. **KD** assured members that NHSE have been working with colleagues in HMPPS to scale up understanding and delivery of vaccines and boosters. Clinical leads and providers are working to ensure as many people in prison as possible are getting vaccinated. KD pointed out that there would be a delay in providing the boosters due to prior delays in providing initial vaccines.

5.5 **DC** commented on the lack of any proper mechanism to monitor and follow-up recommendations that come out of reviews, investigations and inquests. She asked the Board to look at PFDs on black men who have died in police custody and discuss at a future meeting in the context of the Angiolini Review and policing. Minister Malthouse agreed that the Board would discuss the issue at a future meeting.

Item 6: Deaths in custody dashboard and key custodial updates

6.1 Leads for each place of detention gave an update on deaths in custody data and work being undertaken to reduce deaths.

<u>Secure health settings</u>

6.2 **KS** gave an update on the latest data. The CQC are exploring what more can be done to improve data as well as considering what more can be done to learn from natural cause deaths.

6.3 Some key work highlights included:

- Forthcoming published guidance on the Mental Health Units (Use of Force) Act. There will be a three-month notice period until end of March 2022 for NHS providers to comply with the requirements, with remaining requirements - including body-worn cameras - to come into force May 2022.
- Preparing to introduce a Mental Health Act bill when Parliamentary time allows.

- Moving to the next stage of the Patient Mental Health Safety Improvement Programme to look at reducing suicide in inpatient settings.

6.4 **DC** raised concerns around whether the deaths of children who are voluntary patients but de facto detained are being reported.

Police custody

6.5 **RJ** reported that deaths had increased by one on the previous year. There were no Covid-19 related deaths. The IOPC were independently investigating 92 other deaths following police contact; the Home Office had held conversations with the IOPC to understand the data and next steps. Two relevant PFDs had been published in this period and three inquests had concluded.

6.6 Some key work highlights included:

- The policing minister continued to engage with bereaved families and PCCs on thematic issues relating to deaths in police custody.
- Work in collaboration with the IAPDC on police leadership.
- Publication in July of an Angiolini Review progress update[9]. The College of Policing is developing a one-day national modular programme looking at high risk custody themes in response to recommendations in the review.
- A weekly cross-agency Covid-19 custody working group continues to monitor issues in police custody, particularly in response to the Omicron variant.
- A new process for increased data collection of police custody is being implemented, which will provide greater breakdowns in areas such as age, gender and ethnicity.

Immigration detention

6.7 **PR** stated that there had been one self-inflicted death, the first since 2017, with a further two deaths occurring in hospital post-release. Members of the IAPDC had supported the Home Office with their lessons learned reviews. The published Detention Service Order[10] on deaths in detention had been updated to strengthen the guidance around the identification of potential witnesses after a death in detention.

Prison

6.8 **PC** stated that there had been a significant increase in the number of prison deaths, almost entirely due to Covid-19. There had been an increase in self-inflicted deaths in the latest data, though 2020 had seen the lowest number for several years, despite the challenges of the pandemic. The last few months have seen suicide figures nearer their previous rate, though further increases had been avoided despite regime restrictions and the increase in remand prisoners. Investment has been put into Samaritan postvention

[9] Home Office, *Deaths in police custody: Government Update – 2021*, July 2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1003842/Deaths_in_Police_Custody_-_Government_Update_2021_FINAL_CLEAN.pdf.

[10] Home Office, *Detention Services Order 08/2014: Death in immigration detention*, July 2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1013550/dso-08-2014-_death-in-detention_-v3_GOV.pdf.

services to provide support to prisoners following a self-inflicted death and the Samaritan Listeners had recently celebrated their 30th anniversary working in prisons.

6.9 **PD** asked whether telephone credit would be reinstated to prisoners; **PC** said HMPPS would actively consider it. **PC** also said he would put the Samaritans in touch with relevant leads for the Women's Estate Self-Harm Taskforce.

6.10 **CT** welcomed the dashboard and said that data showing rates of deaths per setting would be helpful. **PC** said the prison Safety in Custody statistics do show these. Minister Malthouse issued caution about comparing rates and stated that looking at rates should not come at the expense of learning from specific cases.

Action 4: Secretariat to consider how to integrate data showing rates into the deaths in custody dashboard.

6.11 **JB** said that CQC were scoping work around natural cause deaths to understand any specific issues or themes that may generate actions or recommendations.

Item 7: Next steps and AOB

There was no other business.

Date of next meeting:
3 May 2022.