HM Government

Ministerial Board on Deaths in Custody

Meeting minutes

23 May 2022

Attendees

Kit Malthouse MP, Minister of State for Crime and Policing, Home Office and Ministry of Justice (MoJ) – **CHAIR**
Victoria Atkins MP, Minister of State for Justice, MoJ
Gillian Keegan MP, Minister of State for Care and Mental Health, Department of Health and Social Care (DHSC)

Sally Grocott (SG), Acting Deputy Director, Scrutiny, Performance and Engagement, Prison Policy, MoJ (lead co-sponsor)
Rachel Pascual (RP), Deputy Director, Prison Safety, Security, Operational Policy and Priority Projects, Prison Policy, MoJ
Caroline Allnutt (CA), 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)
HHJ Thomas Teague QC (HHJTT), Chief Coroner of England and Wales
ACC Nev Kemp (NK), Police Lead (Custody), National Police Chiefs' Council (NPCC)
Justin Russell (JR), HM Chief Inspector of Probation
Jonathan Tickner (JT), Inspector, HM Inspectorate of Prisons *(in place of Charlie Taylor)*
Tony Hirst (TH), Chief Superintendent and Deputy Director for Joint Criminal Justice Inspections, HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)
Kimberley Bingham (KB), Deputy Ombudsman, Prisons and Probation Ombudsman (PPO) *(in place of Sue McAllister)*
Miranda Biddle (MB), Operations Director, Independent Office for Police Conduct (IOPC) *(in place of Michael Lockwood)*
Dame Anne Owers (AO), National Chair, Independent Monitoring Boards (IMBs)
Ashley Bertie (AB), Chief Executive, Independent Custody Visitors Association (ICVA)
Juliet Lyon CBE (JL), Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)
Professor Seena Fazel (SF), IAPDC
Professor Jenny Shaw (JS), IAPDC
Peter Dawson (PD), Director, Prison Reform Trust
Andrew Neilson (AN), Director of Campaigns, Howard League for Penal Reform *(in place of Andrea Coomber QC)*
Deborah Coles (DC), Executive Director, INQUEST
Jacqui Morrissey (JM), Assistant Director, Samaritans

<u>For item 3:</u>
Donna Jones (DJ), Police and Crime Commissioner, Hampshire and Isle of Wight
DCI Kate Gunson (KG) – Senior Police Liaison Officer, Office of the Police & Crime Commissioner for Hampshire & Isle of Wight
Peter Hunt (PH) – Mental Health Lead, Hampshire Constabulary

Apologies

John Thornhill, Chair, Lay Observers' National Council (LO)
Keith Fraser, Chair, Youth Justice Board
Jenny Talbot, IAPDC

Item 1: Welcome, apologies, actions and minutes

1.1 The **CHAIR, Kit Malthouse MP,** welcomed everyone to the meeting and gave a special mention to Sue McAllister, Prisons and Probation Ombudsman, who could not attend the Board but for whom this would have been her final meeting. The **CHAIR** thanked her for her valuable insight and wished her the best for the future.

1.2 Minutes from the last meeting in November 2021 had been approved and published[1]. Minutes and action updates were circulated prior to the meeting. The **CHAIR** asked that comments about the minutes or actions be directed to the secretariat.

1.3 The **CHAIR** reflected that the numbers of deaths across almost all places of detention was high, and that while this may partly be explained by COVID-19, he hoped to be able to understand other relevant factors during the discussion.

Item 2: Key 2021/22 workplan updates and MBDC next steps

2.1 The **CHAIR** advised that the workplan was discussed and agreed by Board members last year, and finalised and circulated in September 2021. This meeting would be the final meeting with this workplan, with a new plan to be set in the coming months.

2.2 **SG** summarised reforms to the frequency and structure of the Board made last year, and the priority areas and themes for the 2021/22 workplan, which were agreed with the co-chairs and the Independent Advisory Panel on Deaths in Custody (IAPDC) last summer. A paper presenting updates and progress against the workplan items had been circulated. Specific sessions had been held to inform work on the risk of self-inflicted death for prisoners on remand and the development of an MoJ strategy for older people in prison. Other areas of key progress included:

- Publication of a cross-government 10-year Drugs Strategy;
- Publication of statutory guidance for the Mental Health Units (Use of Force) Act;
- Improvements to the availability of Samaritans resources in different places of custody;
- The rollout of the latest versions of both Assessment Care and Detention Teamwork in immigration detention and Assessment Care and Custody Teamwork in prisons;
- Development of the Prison Advice and Care Trust Prisoners Families Helpline; and
- Modernisation of the Early Release on Compassionate Grounds process.

2.3 **SG** outlined next steps, which will include evaluating changes to the Board's working model and developing a new workplan for 2022/23 in collaboration with members. The new workplan will track impact as well as project progress, and explore an escalation system for items behind schedule. **SG** invited comments on:

- The working model of the Board following the changes made last year;
- Progress against the current workplan; and
- Ideas for priorities for the 2022/23 plan.

2.4 **HHJTT** noted that item 7d of the workplan, "*Progress work to improve the cataloguing and accessibility of PFDs on the Chief Coroner's website",* is work being undertaken by the Chief Coroner independently of the Board and asked that it be removed from the workplan.

2.5 **DC** said that there were continued issues with the disaggregated data on ethnicity and restraint-related deaths and in particular in learning from these deaths. INQUEST is finalising work

[1] Minutes, Ministerial Board on Deaths in Custody, 30 November 2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1044781/MBDC-November-2021-minutes.pdf

on the use of force, race and ethnicity and how these issues are dealt with in investigations and inquests. **DC** confirmed she will share findings with the Board.

2.6 **JM** noted that on item 1c, *"Explore options for signposting the work of the Samaritans at induction and during the preparation for release in immigration removal centres (IRCs)",* there was a need to consider signposting information and support for non-English speakers. **PR** stated that Immigration Enforcement are revising their interpreter support in IRCs and would welcome feedback.

Action 1: Samaritans and Home Office Immigration Enforcement to discuss the provision of support and information for non-English speaking detainees in immigration detention.

Item 3: Preventing deaths at point of arrest after police custody: work with Police and Crime Commissioners

3.1 The **CHAIR** summarised the background to Home Office and IAPDC work to drive forward a zero-tolerance approach to deaths in police custody, and the response they had received to two requests for good practice from Police and Crime Commissioners (PCCs).

3.2 **JL** explained that they had received 28 responses from PCCs and three from representative bodies which focused on good practice across the thematic areas of:

- Mental health and risk;
- Apparent post-custody suicides; and
- Embedding learning.

3.3 Strong leadership had emerged as a key theme in the responses, though there were gaps in information provided on the use of force and disproportionality. There were a number of examples of good work with Liaison and Diversion (L&D) services, though some forces faced issues with mental health provision. Support post-custody was inconsistent, though good practice was evident in Northumbria where police follow-up on individuals for a period of 12 weeks after release. There were good examples of embedding learning from deaths within police forces, though more could be done to involve bereaved families and share learning across forces. Overall, the IAPDC's interim report makes 23 recommendations. **JL** asked for Board member views on whether these covered the most relevant issues and she asked people to consider what support could be offered by the Board and the Home Office to enable forces to protect lives.

3.4 The **CHAIR** introduced Donna Jones to outline local examples of good practice. **DJ** welcomed the IAPDC report. She noted that 19 people had died during or following police contact last year, of which 12 had mental health concerns. In the 48 hours following release there were 54 apparent suicides, of which 38 had known mental health issues and 26 had been detained for sexual offences, a demographic known to be at particular risk. Unmet mental health need is having a significant impact on police time. On post-custody suicides, **DJ** felt the onus is often on people released to reach out for support but that this should ideally be the other way around. Hampshire are drug testing everyone in custody as part of a HO-funded project and are expecting this to positively impact signposting options.

3.5 Hampshire have a contract with Secure Care UK to provide mental health ambulances. One hundred percent of s135 warrants undertaken by Hampshire are attended by mental health ambulances, with a police officer staying with the individual until the ambulance arrives. **DJ** offered to share data on the positive impact this is having and stated that Prime Minister Theresa May had previously committed to rolling out such provision across the country. Hampshire has three large custody suites and ensure that all their custody officers have ligature cutters. Cells have clear CCTV, thorough checks are made of anti-rip clothing, and internal inspections of central custody

are carried out bi-annually. **DJ** suggested that more mental health assessments need to be provided for those leaving custody.

3.6 **JM** noted that staff in some custody suites across the country also make referrals, with the consent of the individual, so that the Samaritans can follow-up with them, rather than relying on the person to make the call themselves.

3.7 **DC** commended ongoing work in Hampshire between police and healthcare and noted the importance of this key relationship. She called for full investment on mental health provision for people in crisis and asked about the role of the Mental Health Crisis Care Concordat. She referenced the findings from an inquest into the death of Kelly Hartigan Burns, which was critical of mental health care for vulnerable women, and suggested that there was a lot of learning in the report for custody suites.

3.8 The **CHAIR** noted the need to develop a better relationship between policing and mental health services and that he had discussed this with GK. He noted good work by the police in Humberside to develop collaborative relationships with local healthcare services which has reduced demands on the police.

3.9 **JM** welcomed the report and noted that proactive support is important to get help for those released from custody, and that the new National Suicide Prevention Plan is currently being consulted on and it would be worthwhile to consider how this work could feed into that. She suggested that there should be a central dedicated monitoring system to share and embed learning from custody deaths. **NK** confirmed that support information is routinely given to vulnerable people upon leaving custody, but a proactive service would be a positive move.

3.10 **GK** referenced good work in building up community mental health teams and the reform of the Mental Health Act which will reduce the use of police and prison cells being used as places of safety. She encouraged Board members to respond to the call for evidence into the Mental Health and Wellbeing 10-year plan.

3.11 **SF** questioned evaluation evidence behind L&D programmes globally as well as in England and Wales and stated that there was a shortage of evidence. **KD** explained that the RAND evaluation of L&D had a significant number of contributors (over 10,000 service users), though she accepted it had taken place at a particular moment in time and could be revisited now that L&D was an embedded NHS England service provision. **KD** welcomed the report, stated that it was timely and called for it to recognise the need for forces to link with local pathways, including the 42 integrated care boards. The **CHAIR** agreed with the suggestion to revisit research on L&D.

3.12 The **CHAIR** asked DHSC for an update on a rollout timetable of Theresa May's mental health coverage commitment. **GK** confirmed discussions were ongoing with other departments and would feedback to the Board. **CA** added that the rollout of mental health crisis helplines had been fast tracked across the country as a result of the pandemic and £150m capital funding has been committed to supporting mental health services, including to support crisis care.

3.13 **JL** explained that the report would be launched at an event during the summer, where it is hoped Minister Malthouse and Minister Keegan will contribute. She added that the IAPDC would consider adding further research on Liaison and Diversion as an additional recommendation to the report**.**

Action 2: DHSC to provide an update on the rollout timetable of Theresa May's coverage commitment in policing for mental health ambulances.

Action 3: IAPDC to update the *Preventing deaths at point of arrest, during and after police custody* report based on the Board discussion and report back on progress at the next meeting.

Item 4: Preventing deaths of people detained under the Mental Health Act

4.1 **CA** updated on recent work to prevent future deaths of those detained under the Mental Health Act:

- During the period covered by the pandemic, deaths of patients detained under the Mental Health Act have increased significantly compared to previous years. DHSC is working with NHS England and Improvement and CQC to take steps to address this.
- The Queen's Speech in May announced Government's intention to publish a draft Bill to reform the Mental Health Act. We anticipate the draft Bill will be published in the next few weeks. This is a flagship area of reform aimed at providing greater transparency of decision making, putting onus on clinicians to justify detentions, and give patients a greater say over their care and treatment.
- Statutory guidance has been published on the Mental Health Units (Use of Force) Act, and DHSC are working with the CQC to implement the requirements about investigations relating to the use of force.
- The Mental Health Safety Improvement Programme has set up patient safety networks covering all regions and the NHS is working on the roll out of the Patient Safety Incident Response Framework.
- A call for evidence for the 10-year Mental Health and Wellbeing plan is open until 7 July. This covers all aspects of mental health prevention, treatment and support, including inpatient care and suicide prevention.
- An update on all current work and improvements on quality of data will be provided at the next meeting in November. Current data is limited and has gaps, including in ethnicity information.

4.2 The **CHAIR** said forthcoming reforms to the Mental Health Act made this a key moment to discuss the deaths of people detained under the Act, and requested this be a substantive item at the next meeting.

4.3 **DC** raised the lack of an independent investigatory body like the PPO or IOPC to investigate deaths in Mental Health Act detention and suggested discussing this with DHSC ahead of the November meeting. **SF** questioned how much impact changes to legal frameworks would have on reducing deaths and improving treatment of physical health conditions. **CA** said that NHS colleagues would provide further detail current work on to address the physical health of people with serious mental illness at the next meeting.

Action 4: DHSC and NHS England to prepare an item on all current work and improvements on data quality in secure health settings for discussion for the next meeting.

Item 5: Safely managing the projected expansion of the prison estate

5.1 **PD** introduced his paper, drawing the attention of the Board to: the risks faced by HMPPS in the context of rising prisoner numbers and falling prison officer numbers; the impact of these dynamics on safety and deaths in custody; and proposals for the mitigation of these risks. He stated that the prison service had been in a similar situation before in the early 2010s when the staff to prisoner ratios had fallen and as a result safety had decreased. He stated that the biggest impact will likely be to local prisons, who already cope with the worst levels of overcrowding and the highest rate of deaths. His paper made two recommendations:

a. That other parts of the system, such as Probation and Health, help to reduce demand in prisons, and
b. Accountability through independent, expert and external review of the impact on safety.

5.2 **VA** thanked Peter for raising these issues, and reassured Board members that the government is looking at prison safety metrics carefully, and that a great deal of work is being done on the recruitment and retention of staff.

5.3 **PC** referred to measures being taken to mitigate risk, including increased funding for the provision of Mental Health Treatment Requirements and the proposed change to the Mental Health Act to introduce a statutory 28-day timeframe for moving prisoners in need of treatment to hospital, which would reduce some of the pressure on the prison system. He referred to work to assess recalls, which had found no significant issues of inappropriate or unnecessary recalls. There were initiatives to improve the staffing position, with non-pay interventions to better support new staff such as buddy and mentoring schemes, and this year's pay award would be important in improving both the recruitment and retention of staff; an improved staffing position was essential to enable post-Covid recovery of regimes and Offender Management (both casework and key work), which were important to safety. Several further, specific safety measures would be funded, such as the delivery of nearly 300 ligature-resistant cells, and piloting in-cell technology that monitored vital signs. Safety was a central strategic concern and **PC** welcomed the Board, IMBs and HMIP providing independent challenge on this issue. He committed to HMPPS working transparently and more intensively with the IAPDC on deaths in custody, sharing data and analysis about trends and intelligence. **JL** said the IAPDC would work with PC and PD to monitor safety risk and steps taken in mitigation. A brief will be produced for co-chairs. She added that improving support and supervision for staff was important.

Action 5. IAPDC, in conjunction with HMPPS and PRT, to produce a monitoring brief for ministers on risk in expanding the prison estate and mitigation.

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.

Immigration detention

6.2 **PR** said that there had been no deaths in immigration detention in this period, and welcomed close working with NHS England to keep people safe during COVID-19. Current focus was on short-term detention and ensuring the safety of those arriving by small boats. One PFD report had been received during this period.

Secure health settings

6.3 **CA** detailed the recent interim data and highlighted that the causes of a high number of deaths were still to be determined. **DC** said this was unacceptable and pointed towards the HMPPS system, which does not require waiting for coroner verdicts to determine cause, as good practice. The **CHAIR** and **VA** agreed and suggested that this point should be covered at the next meeting.

Police custody

6.4 **RJ** explained that there had been 19 deaths during or following police contact last year, of whom two were BAME, and 54 apparent suicides post release. There had been three recent PFDs, of which two related to mental health.

Prison

6.5 **PC** said that the rate and number of deaths had decreased significantly in the 12 months to March 2022 (the rate had fallen by 29%), largely due to far fewer COVID-19 deaths (over 60% of all Covid deaths occurred in the 6 months October 2020 to March 2021). Self-inflicted deaths were also down in the most recent period, though he reminded members that due to low numbers there can be volatility and trends from this data should be treated with caution. The Samaritans had been given a renewed grant of £625k/year until March 2025 to continue to support the Listeners scheme and also to provide a new postvention support programme. The **CHAIR** requested a breakdown on deaths in Approved Premises for the next dashboard, as the numbers are as high as those in police custody.

Action 6: Secretariat to work with HMPPS to explore incorporating a breakdown of Approved Premises deaths into the dashboard.

Item 7: Next steps and AOB

7.1 There was no other business.

7.2 The **CHAIR** thanked attendees for a productive meeting.

Date of next meeting:
3 November 2022