Ministry of Justice | Home Office | Department of Health & Social Care

Ministerial Board on Deaths in Custody meeting minutes, 17 May 2023

Attendees

Maria Caulfield MP, Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy, Department of Health and Social Care (DHSC) (Chair)
The Rt Hon Damian Hinds MP (DH), Minister of State for Prisons, Parole and Probation, Ministry of Justice (MoJ).
The Rt Hon Chris Philp MP, Minister of State for Crime and Policing, Home Office (HO)

Paul Norris (PN), 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
David Hull (DaH), Head of Police Powers Unit, HO *(in place of Richard Jolley)*
Frances Hardy (FH), Acting Head of Detention Services, Immigration Enforcement, (HO)
Phil Copple (PC), Director General, Operations, HM Prison and Probation Service (HMPPS)
Fiona Grossick (FG), National Clinical Quality Lead, NHSE *(in place of Kate Davies)*
Cathy Edwards (CE), Clinical Programmes Director, NHSE and NHS Improvement
DCC Nev Kemp (NK), Police Lead (Custody), National Police Chiefs' Council (NPCC)
PCC Emily Spurrell, Joint Lead for Mental Health and Custody, Association of Police and Crime Commissioners
Lizzy Renard, (LR), Head of Policy, HM Inspectorate of Prisons *(in place of Charlie Taylor)*
Adrian Usher (AU), Prisons and Probation Ombudsman (PPO)
Miranda Biddle (MB), Operations Director, Independent Office for Police Conduct (IOPC) *(in place of Tom Whiting)*
Chris Dzikiti (CD), Director of Mental Health, Care Quality Commission (CQC)
Norma Collicott (NM), Assistant Portfolio Director, HM Inspectorate of Constabulary and Fire & Rescue Services
Dame Anne Owers (DAO), National Chair, Independent Monitoring Boards (IMBs)
Sherry Ralph (SR), Chief Executive, Independent Custody Visitors Association (ICVA)
John Thornhill (JT), Chair, Lay Observers
Jamie Bennett (JB), Chief Strategy Officer, Youth Justice Board (*in place of Keith Fraser)*
Lynn Emslie (LE), Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)
Professor Seena Fazel (SF), IAPDC
Professor Jenny Shaw (JS), IAPDC
Pia Sinha (PS), CEO, Prison Reform Trust
Andrea Coomber (AC), Chief Executive, Howard League for Penal Reform
Deborah Coles (DC), Executive Director, INQUEST
Jacqui Morrissey (JM), Assistant Director, Samaritans

For item 3:
Professor Sir Louis Appleby (LA): Chair, National Suicide Prevention Strategy Advisory Group
For item 5:
Dr Geraldine Strathdee (GS), Chair, Rapid Review into Data on Mental Health Inpatients

Apologies

HHJ Thomas Teague QC, Chief Coroner of England and Wales
Jenny Talbot, IAPDC

Raj Desai, IAPDC
Justin Russell, Chief Inspector, HM Inspectorate of Probation

Item 1: Welcome, apologies, actions and minutes

1.1 The **CHAIR** thanked everyone for attending the meeting in-person. She welcomed new members: Lynn Emslie, Chair of the Independent Advisory Panel on Deaths in Custody; Adrian Usher, Prisons and Probation Ombudsman; Police and Crime Commissioner Emily Spurrell, Mental Health and Custody lead for the Association of Police and Crime Commissioners; and Pia Sinha, CEO of the Prison Reform Trust.

1.2 Apologies had been received from the HHJ Thomas Teague QC, the Chief Coroner, and Justin Russell, HM Chief Inspector of Probation.

1.3 Minutes from the last meeting in November 2022 had been approved and published. Minutes and action updates were circulated prior to the meeting. The **CHAIR** asked that any comments about these be directed to the Secretariat.

1.4 The **CHAIR** reflected that the numbers of deaths across all custody settings remained high and that she was keen to understand the work that departments were taking forward in response.

Item 2: Board next steps and the 2023/24 workplan

2.1 **PN** gave a background to the 2021/22 workplan which had run slightly longer than originally anticipated due to ministerial turnover.

2.2 **PN** updated on an evaluation of the Board conducted with the membership earlier in the year. Responses had been broadly positive, including around agenda setting and the introduction of the dashboard and workplan to shape discussion and focus. Members had asked to maximise the role of ministers in these meetings. Members made suggestions which will be incorporated into arrangements going forward, including on new publications to increase transparency of the Board's work and the development of an escalation process for workplan items deemed behind schedule. In response to concerns raised around anticipating risk, a focus on horizon scanning had been added to the dashboard and risk planning had been identified as one of three priority areas in the new workplan.

2.3 **PN** explained that items for agendas are considered by departmental leads ahead of each meeting. He encouraged members to suggest ideas for agenda items and policy forum subjects to the Secretariat for consideration.

2.4 **PN** updated on the new 2023/24 12-month workplan. The Secretariat worked with co-sponsoring departments, the IAPDC and other relevant organisations to produce a draft 2023/24 workplan and to shape three priority areas. These are:

i. *Treatment and care* – ensuring systems work together effectively to provide adequate treatment for those experiencing mental and physical illness.
ii. *Investigations and learning* – improving local and central post-death processes to ensure lessons are identified and embedded.
iii. *Risk and forward planning* – ensuring departments and agencies are anticipating risk, trends and areas of concern, and continuing to enhance data sources and the evidence base.

2.5 **PN** acknowledged that the plan is ambitious but that the team will be working to ensure progress is monitored and impact measured. After this meeting, the secretariat will work with sponsoring departments and other relevant organisations to identify clear timelines and measurable intended outcomes for each item. He asked Board members whether they agreed with the three priority areas and for comments on individual items in the workplan.

2.6 **AU** indicated that his initial impressions of the PPO role suggested that item 38, which focuses on repeat recommendations, was too restrictive. He indicated that he wants to provide HMPPS with thematic and positive impact reports. **DH** welcomed the suggestion and **PN** agreed and said that he was happy to liaise with the PPO to adjust the wording following the meeting.

2.7 **JB** asked that the specific needs of children be considered wherever possible in the workplan, including relating to family support. **DAO** raised the importance of prioritising key work in prisons. People in prison are often currently receiving just one session a month rather than the intended one session per week as a result of staffing and population pressures. She urged HMPPS to do more to protect the most vulnerable. **DAO** referenced workplan items on transfers from prison to hospital and on ending the use of prison as a place of safety, both of which had been highlighted in a recent IMB report on mental health concerns in women's prisons. Without the necessary health resources being put in place it was difficult to see how the aims of the Draft Mental Health Bill could be achieved. **RP** agreed that there was a need to look into whether key work was working as intended and **PC** accepted issues existed and was happy to include action to address this in the workplan.

Action 1: Secretariat to liaise with relevant organisations to identify timelines and measurable outcomes for items in the 2023/24 Board workplan and address points made about individual items.

Item 3: Cross-government suicide prevention strategy

3.1 The **CHAIR** invited Professor Sir Louis Appleby, Chair of the National Suicide Prevention Strategy Advisory Group to give an update on the strategy, which DHSC hope to publish before summer recess.

3.2 **LA** outlined that there were over 5,000 registered suicides in 2021 and that suicide was the leading cause of deaths in men and women below the age of 35. The new strategy looks at key groups of concern, drivers of suicide, work with the media, bereavement support, awareness of methods of suicide, and data. Middle aged men have the highest suicide rates and are a key group of concern. There were 1,300 deaths of mental health patients every year and 74 self-inflicted deaths of prisoners in the 12 months to March 2022. Once the definition of offenders is broadened to include those released from prison and police custody, numbers rise significantly. Many of these people had previously been in contact with other services, which raises questions around risk management. The strategy is cross-government and involves a range of organisations from government departments through to frontline agencies. It will look at priority areas and specific practical measures that are achievable within the next five years, as well as how to ensure monitoring and accountability. He invited comments from Board members on key priority areas, specific, practical measures achievable within the next five years, and thoughts on delivery and accountability.

3.3 **SF** introduced work conducted by the IAPDC on the strategy. He outlined that the Panel welcomed the opportunity to feed into this work. The previous strategy included only a short section on people in contact with the criminal justice system, and the Panel are pleased that there are indications that this will be developed and expanded. The Panel had submitted a paper to DHSC on suicide prevention, which had been circulated to members, in which they had identified eight themes. These included:

- Linkage – one of the most important moments of risk is when an individual transitions out of or between institutions. Processes and information sharing during this period need to be improved.
- Environment and custodial landscape – this should including removing ligature points in cells and improving contact with family and support networks.
- Alternatives to custody – numbers and rates of self-inflicted deaths in custody are high, suggesting non-custodial alternatives need to be considered.
- Learning from independent reviews and near misses.
- Research – the evidence base is limited on interventions and optimal types of services.

3.4 **SF** concluded that the Panel were keen to continue to be involved in the development of the strategy, in supporting its implementation and in monitoring recommendations.

3.5 **DH** agreed with the themes selected by the Panel and was supportive of alternatives to custody. He noted that capacity challenges placed restraints on key work and other available responses and that the secure estate has to enact the will of the courts.

3.6 **DC** stated that INQUEST welcomed the strategy and raised that often people who die in detention have had their own experience of traumatic bereavement but this is mostly not recognised by the relevant agencies as being important to their treatment and care. Related to this was the difficulty that bereaved families face in accessing bereavement support following a death. Families cannot begin to grieve until the outcome of the investigation or inquest, which often take place long after the event. More accessible bereavement support is important for minimising ongoing risk. **LA** agreed and stated that over the last decade, services were becoming more aware of the psychological impact of bereavement. He was aware that NHSE has been carrying out work to increase bereavement support.

3.7 **LR** agreed with points raised about transition points. HMI Prisons have flagged concerns around current time out of cell and regime levels. Ensuring that prisoners have a sense of purpose and good staff-prisoner relations should be key part of the strategy. **JM** welcomed the IAPDC's report and asked that it makes a commitment to reaching the lowest recorded suicide rate. People should never die by suicide when in the care of the state, and staff leadership, culture and training is important. She flagged that Samaritan Listeners in prisons are struggling to facilitate contact with prisoners due to a lack of staff. The strategy should include practical points of delivery to help staff on the ground deal with everyday issues. These actions should not just be for prisons but across all settings.

3.8 The **CHAIR** stated that the strategy should be published by the next meeting, and the Board could then look at how key areas could be implemented across places of detention.

3.9 **ES** reinforced the point made in the IAPDC's report of the importance of taking a trauma-informed approach. **LA** observed that the pathway to suicide comes from a combination of factors. People in detention settings often have other issues – for example relationships, alcohol and substance misuse, poverty – and suffer problems living on the margins of society. He wanted to reflect this in the strategy.

Item 4: DHSC rapid review into the safety of mental health inpatients

4.1 **CA** explained that the review had been commissioned at the beginning of the year following media stories about poor care and abuse in inpatient settings. The Government wanted to tackle this through the use of data and information and to scope whether indicators can precipitate more proactive preventative action. The review's objectives are to review all data collected on mental health inpatient services and to understand how data streams are used and acted on. This includes

understanding how the experiences and views of patients, families, staff and advocates are collected, analysed and used, and how this is used to identify risk factors for inpatient safety; whether people are receiving high quality care and being cared for in a safe and therapeutic environment; and how data and intelligence is used by providers and local commissioners to reduce risk and drive a proactive culture of improvement. The review process was nearly complete and DHSC hope to publish findings soon.

4.2 **GS** explained that the review's report was currently with ministers. The review team had looked at industries where safety had been transformed. Discussions took place with those experiencing services and those delivering them, from all regions and from all backgrounds. The review team undertook deep dives on the NHS and the independent sector, with regulators and other organisations. The review aims to identify good practice and had asked a range of questions including what data is need to keep people safe and what is required to most improve safety.

4.3 **GS** summarised initial emerging findings. These included that there is often an assumption that mental health trusts do not have much data. In fact the contrary is true – organisations feed into 72 national datasets, though the data is often in different formats. Those who enter data are usually frontline clinicians and their time ought to be freed up as much as possible to provide for patient care. Those with lived experience and frontline staff want data collected that matters, while much of it is actually about processes, activity and performance. Data should be focussed on the people (age, gender, ethnicity), what problems they are facing, and what therapeutic interventions they are receiving. Some good practice has been identified, including in one organisation which has pulled together all digital information under one platform to eradicate duplication of data.

4.4 The **CHAIR** agreed that the challenge was to sift through the information to get at the right data. **CD** welcomed the work and understood the need for frontline staff to have sufficient time for patient care.

4.5 The **CHAIR** asked what indicators existed in prisons to quickly highlight someone at high risk. **PC** stated that prisons have screening processes carried out by health staff but that these can get overstretched by prisoner numbers. These processes identify risk factors that are very prevalent among prisoners, making it difficult to identify those immediately at risk, though processes are in place to identify immediate problems.

4.6 **DC** highlighted that the Board has been raising the issue of significant gaps in deaths data of those detained under the MHA for over a decade, and she was keen to read findings on this in the review. She also pointed to repeat failings being identified on a regular basis at inquests for deaths in these settings and was interested to know how the review will propose that organisations might better learn from evidence coming out of those processes. **DC** stated her concerns that the status of the inquiry into the deaths of mental health inpatients in Essex was still not known and that people had been reluctant to give evidence. There was an opportunity now to link the work of the review and the inquiry to look at these long-standing issues.

4.7 **GS** stated that a further issue was that for the majority of deaths the cause of death is 'undetermined', which is often a result of the length of time taken for inquests to be completed. This has been identified as a challenge in the review. Additionally, the determination of a death as 'natural' is unhelpful, as while it may come from a physical cause, people with mental ill health die 20 years prematurely with greater physical comorbidities, for instance, due to heart disease and drug and alcohol misuse. It is not appropriate, in her view, to describe the death of a 27-year-old in a diabetic coma in an in-patient unit as 'natural'. She noted that in some areas, the result of an inquest will be fed back to the trust, but in other areas it is not and this is an issue. It was important for all information about a person to be held in the same place, which it is not at present. The body of the report contains practical examples of what can be done.

4.8 **PS** stated that the Prison Reform Trust have been looking at data and have noticed a trend on the disproportional numbers of women convicted of assaulting emergency workers. This cohort

often has high levels of prolific self-harming. She also flagged the high numbers of deaths of women following release from custody.

Item 5: Independent Advisory Panel on Deaths in Custody update

5.1 **LE** reflected on her first months in her new role as Chair of the IAPDC. She explained that she had a background in health and social care and had identified emerging focus areas including MHA detention, information sharing and embedding learning. She thanked Panel members coming to end of their tenure. She explained that Raj Desai, a human rights barrister, had joined recently and that Dr Jake Hard, current Clinical Director at HMP Cardiff, and Pauline McCabe OBE, a former Prison Ombudsman for Northern Ireland, would be taking up post in July. The Panel were therefore well placed to deliver their workplan and to inform and advise ministers.

5.2 **LE** outlined the new IAPDC workplan. The plan aligns with the three priority areas of the Board's workplan and she committed to feeding back on outputs and progress. The Panel hope to be involved in future work on the suicide prevention strategy and rapid review on data discussed earlier in the meeting. On Preventing Future Deaths reports, the Panel have been working with the Chief Coroner to attract greater attention to the importance of these reports. Since the last Board meeting the Panel has gathered further evidence from bereaved families and agencies and services and are now finalising a report.

5.3 The Panel have published a report on deaths involving the police, having worked closely with Police and Crime Commissioners (PCCs) to identify a wide range of good practice. The report focused on three priority areas: mental health and risk, apparent post-custody suicides, and embedding learning. **LE** thanked Board members involved in this work to date. The report highlights how to reduce inappropriate use of police time and build partnerships, while raising concerns that practice is not consistent, with limited evidence that forces are sharing findings after a death or working with healthcare partners to provide effective support for vulnerable individuals. Next steps are to work with PCCs and police leadership to disseminate the findings and ensure that developments, such as the National Partnership Agreement and the rollout of the 'Humberside model' regarding policing and mental health, have a strong focus on the importance of preventing deaths connected to contact with the police.

5.4 Over the next six months a longer workplan will be developed to take the Panel into the next year. The Panel will also be developing a "handbook", a document that will collect historical work and flag repeat recommendations.

Item 6: Deaths in custody dashboard and key custodial updates

6.1 The **CHAIR** invited leads for each place of detention to give an update on data and work being undertaken to reduce deaths.

Prisons

6.2 **PC** noted the increase in deaths in the most recent statistics. The increase in self-inflicted deaths is a key area of concern. If current rates continue, 2023 will see the highest number of self-inflicted deaths since 2016. Clusters of deaths are another area of concern. The prison population is increasing and although HMPPS are increasing the supply of new places it is struggling to keep pace. Staff shortfall in some establishments is affecting key work and the provision of purposeful activity. There has also been an increase in cohorts arriving in prisons such as remand and recall

with these populations greater than previously. In relation to Operation Safeguard, HMPPS are prioritising prison custody for those identified as high suicide risk rather than using police cells. An Early Days toolkit has been rolled out and in-cell telephony has been rolled out to all but 12 establishments, which will receive it this year. Samaritans have trained over 1,300 prisoners to act as peer supporters and have rolled out a postvention programme for support to staff and prisoners following a death. HMPPS have also had to increase capacity in prisons to accommodate the extra numbers of prisoners.

Immigration detention

6.3 **FH** stated that there remained very low numbers of deaths in immigration detention. However, the estate is facing similar capacity challenges to prisons and there had been one death in March which was being investigated by the PPO. Work is ongoing to ensure that learning from previous PFDs is properly embedded. The fatal accident inquiry into the death of Mr Huang had just concluded and the Home Office is drawing relevant learning. Several different workstreams are ongoing, including research to understand who was being detained, the impact of detention and how to manage self-harm. They are also reviewing near miss data to identify trends and embedding lessons learned from coroners, the PPO and prison deaths.

Police custody

6.4 **DaH** stated that there had been 11 deaths to March 2022, down from 19 the previous year. Of these, four involved restraint, six were identified as having mental health concerns, and nine involved alcohol/drugs. For the first time the dashboard also included data on the IOPC's category of "other" deaths following police contact. Seven of these involved restraint/use of force. **DaH** referenced two PFD reports from the dashboard and relevant learning, particularly regarding the lack of mental health awareness among staff. The College of Policing are rolling out HYRDA training for officers to identify vulnerabilities prior to release.

Detention under the Mental Health Act

6.5 **CA** stated that the interim data from CQC showed there were a high proportion of deaths of people held under the Mental Health Act from undetermined causes. Trends show that numbers of deaths have come down significantly although they are slightly higher than pre-pandemic. Key areas of work are the rapid review, the draft Mental Health Bill, and the suicide prevention strategy. On the latter, £10 million has been given to the voluntary sector to support suicide prevention.

6.6 **AC** highlighted her concerns about government refusal to accept the Justice Select Committee's recommendations on IPP prisoners. She noted there had been several self-inflicted deaths among this cohort since January and asked what was being done to support them. She raised concerns that safer custody teams had advised the charity that they did not have capacity to respond to urgent issues around the safety of children and IPP prisoners at risk. **AC** was worried that staffing constraints are leading to the de-prioritisation of safety.

6.7 **DH** agreed that IPP prisoners were a cohort of particular concern. This sentence would not be used today and he would like to see the population managed towards a safe release. The approach is to look at each individual according to their need rather than a group with a defined set of needs. **AC** stated that HMPPS had advised, in response to the JSC report, that prisons with high IPP prisoner populations receive additional support. Other Board members stated that while this may happen in some areas, the response on providing preventative measures was patchy across the estate.

6.8 The **CHAIR** stated that for the next meeting in October she would like to hear more about natural cause deaths and undetermined causes of deaths as these represent a large percentage of the data. She also asked for an update on work being done to support the mental health of IPP prisoners.

Action 2: DHSC to coordinate an update on data relating to deaths of people detained under the Mental Health Act, with a specific focus on deaths from 'natural' and 'undetermined' causes.
Action 3: HMPPS to outline mental health and other support provided to IPP prisoners at October meeting.

Item 7: AOB

7.1 There was no other business.

7.2 The **CHAIR** asked Board members to send any suggestions for agenda items for the next meeting to the Secretariat, and thanked attendees for a productive meeting.

Date of next meeting: 23 October 2023