HM Government

Ministerial Board on Deaths in Custody

Meeting minutes

22 November 2022

Attendees

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

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
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
HHJ Thomas Teague QC (HHJTT), Chief Coroner of England and Wales
DCC Nev Kemp (NK), Police Lead (Custody), National Police Chiefs' Council (NPCC)
Amelia Johnson-Manley (AJM), Senior Adviser, HM Chief Inspector of Probation *(in place of Justin Russell)*
Martin Lomas (ML), Inspector, HM Inspectorate of Prisons *(in place of Charlie Taylor)*
Kimberley Bingham (KB), Acting Ombudsman, Prisons and Probation Ombudsman (PPO)
Miranda Biddle (MB), Operations Director, Independent Office for Police Conduct (IOPC) *(in place of Michael Lockwood)*
Chris Dzikiti (CD): Director of Mental Health, Care Quality Commission (CQC) *(in place of Jemima Burnage)*
Dame Anne Owers (DAO), 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
Peter Dawson (PD), Director, Prison Reform Trust
Keith Fraser (KF), Chair, Youth Justice Board
Anita Dockley (AD), Research Director, Howard League for Penal Reform *(in place of Andrea Coomber QC)*
Deborah Coles (DC), Executive Director, INQUEST
Jacqui Morrissey (JM), Assistant Director, Samaritans

For item 4:
Liz Durrant (LD): Mental Health and Autism, NHS England

Apologies

John Thornhill, Chair, Lay Observers' National Council (LO)
Jenny Talbot, IAPDC
Professor Jenny Shaw, IAPDC
Norma Collicott, HM Inspectorate of Constabulary and Fire & Rescue Services

Item 1: Welcome, apologies, actions and minutes

1.1 The **CHAIR** welcomed everyone to his first Ministerial Board on Deaths in Custody (MBDC) meeting and outlined that he hoped to be able to hold these meetings in person in the future. He gave a special mention to Juliet Lyon, Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC). Juliet has been a member of the Board since its inception, first as Director of the Prison Reform Trust and now as Chair of the IAPDC. The **CHAIR** thanked her for her service and her contributions to the Board, and wished her the best for the future.

1.2 Minutes from the last meeting in May 2022 had been approved and published. Minutes and action updates were circulated prior to the meeting. The **CHAIR** asked that comments about these be directed to the secretariat. The action on capacity and staffing in prisons that was raised at the last meeting by the IAPDC and the Prison Reform Trust would be discussed later in the custodial updates section.

1.3 The **CHAIR** reflected that the dashboard showed continuing high numbers of deaths across custody and was keen to understand the background behind the statistics.

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

2.1 The **CHAIR** advised that members were informed at the last MBDC in May that they were receiving the final update on the 2021/22 workplan, with a new workplan to be introduced at this meeting. However, ministerial changes and delays in appointing the new Chair of the IAPDC have meant that this work has not been taken forward as planned.

2.2 **PN** summarised the priority areas for the 2021/22 workplan, which were agreed last summer. He reiterated that it had not been possible to take forward revisions and a new workplan as planned, so a further update had been carried out on the existing workplan and circulated to Board members. The update set out some areas of key progress:

- Ongoing pre-legislative scrutiny of the draft Mental Health Bill, which a number of the organisations in the meeting had contributed to.
- Rollout of the postvention support service in prisons and delivery of the Prison Advice and Care Trust (PACT) Prisoners' Families Helpline toolkit.
- Implementation of provisions from the Mental Health Units (Use of Force) Act.
- The announcement of additional funding for specialised mental health ambulances in June.
- Progression of the rollout of the College of Police's training on de-escalation and conflict.

2.3 **PN** outlined next steps, which would include working with Ministers and Board members to evaluate changes to the Board made in 2021 and drawing up a new workplan for 2022/23 in collaboration with ministers, the IAPDC and other Board members.

2.4 **MC** noted that there was a significant amount of work in train to address issues around Mental Health Act detention, and that there would be further announcements on this in the coming weeks.

Action 1: Secretariat to work with ministers, departments, the IAPDC and other Board members to scope a new MBDC workplan.

Item 3: Prevention of Future Deaths reports

3.1 The **CHAIR** invited **JL** to give an update on the IAPDC's project on coroner-written Prevention of Future Deaths (PFDs) reports.

3.2 **JL** advised that this project aligns with the Board's workplan's focus area of embedding learning and that PFDs are an important part of the coroner role. The preventative potential of PFD reports is not being fully realised and this issue has been raised at previous Board meetings. For this project, the IAPDC conducted a sampling exercise of PFD reports across custodial areas and consulted coroners at two roundtable events. Coroners had been candid and forthcoming on their ideas of best practice and on required improvements. A range of issues, including around distribution of reports to bereaved families and all relevant authorities, had been identified. Next steps will include consulting bereaved families and staff in custodial settings which respond to the reports. The final report will be published in the new year.

3.3 **HHJTT** stated that he was pleased that the roundtables had been useful. He indicated he will be bringing a renewed focus to PFDs in the coming year. For instance, they will be included in the mandatory coroner judicial training from April 2023. The Chief Coroner's Office has made improvements to the judiciary website and are working with an academic from the University of Oxford to develop a preventable deaths tracker. These will continue with work to ensure that all newly published reports are text searchable. Work was in progress to publish new PFD bulletins highlighting any emerging trends. **HHJTT** outlined how he is in favour of outreach by coroners in community and in prisons and for ensuring improvements to the distribution of PFDs, particularly to families of the deceased, and will communicate his expectations to coroners. **HHJJT** highlighted that the judicial independence of coroners must not be infringed. He referenced an upcoming High Court judgement relating to a death in prison which could have implications for wider PFD practice.

3.4 The **CHAIR** asked for clarification on the thematic bulletins. **HHJJT** stated that these will be basic thematic publications and that he did not have the resources to coordinate with the work of other organisations or provide statistical trends. The sooner he could alert others to emerging trends the better.

3.5 **DC** stated that this has been an ongoing concern for INQUEST, as bereaved families have commented that they rarely hear from organisations about changes made in response to PFDs. There is a lack of resources for the Chief Coroner to follow-up and monitor responses and no tracking of action taken or sustained by receiving organisations. An oversight mechanism to enable proactive follow-up could address this. **DC** raised concerns around discussions at the conclusion of an inquest on whether a PFD report should be made, with lawyers often discouraging coroners on writing one. This undermined the role that the reports play in preventing deaths from a national perspective – an inquest should be an opportunity to scrutinise. **DC** pointed to previous good practice in this area – in the past, Rule 43 report bulletins were produced which looked at issues thematically. The **CHAIR** committed to factoring relevant comments on PFDs from members into the next workplan.

3.6 **JM** stated that issues about PFD follow-up and learning from deaths were not just relevant to custody but the wider community. She had a specific concern about people being made aware about new and emerging methods of suicide through PFD reports. **HHJTT** stated that coroners do have a redaction methodology and that he was happy to meet Samaritans to discuss their concerns.

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

4.1 **KS** outlined how recent media coverage of mistreatment and abuse of patients in secure hospitals has underlined the importance of this discussion. Deaths in secure settings were slightly down this year with fewer natural deaths as a result of COVID-19, though there was a concerning rise in non-natural deaths. She updated on recent work to prevent future deaths of those detained under the Mental Health Act:

- The draft Mental Health Bill is currently going through pre-legislative scrutiny. It includes a number of changes that Board members have called for, including the introduction of a statutory time limit for transfer from prison to hospital and ending the use of police and prison custody as designated places of safety. More widely it will provide more choice and access to independent advocates to patients. The Bill is clear that detention should only be used where there is a reasonable expectation of therapeutic benefit.
- The NHSE quality improvement programme has been looking at how to make cultural changes a reality on mental health wards, while more funding for mental health ambulances has been made available.
- The majority of provisions in the Mental Health Units (Use of Force) Act commenced in March. The use of body cameras for officers assisting at a mental health unit commenced in August and the rest of the provisions will be enacted soon.
- DHSC have been working with the Board secretariat, the NHS and the CQC to consider concerns about reporting and recording data of people detained under the Mental Health Act. DHSC can provide an update at a future Board meeting.
- There had been a good response to the call for evidence on suicide prevention and DHSC were grateful for a session organised by the IAPDC on custody suicides specifically as part of this work.
- The new Patient Safety Incident Framework was published in August and will be implemented next autumn. This stops short of introducing an independent body to investigate all deaths in mental health settings, something that some Board members have been calling for.

4.2 **CD** gave an overview of the new Single Assessment Framework, which will allow the CQC to make more frequent inspections of the poorest performing providers. Underpinning the framework is the ability to gather data to inform judgements on when to conduct inspections. There are six evidence categories: people's experiences, feedback from staff and leaders, observation of what is happening in services and how staff interact with patients, feedback from partners, processes, and outcomes of care.

4.3 **LD** explained that there were well evidenced risk factors and work needed to be focussed on mitigating these. Extended stay in hospitals bring heightened risks such as infection and people not recovering as well as they could at home. In mental health detention interventions can be traumatising and impact on a person's sense of self. Many institutional settings are located in remote areas meaning patients are located far away from loved ones, and therefore poor care is less likely to be observed and reported. There was a need to focus more specifically on the commissioning of inpatient services. NHS England need to be more alert to spotting signs of a closed culture and looking at the approach to governing and overseeing those settings; they must listen to patients and their families. The CQC have carried out work on closed cultures; the current quality assurance mechanism may give a false sense of assurance as it does not highlight key concerns. There are particular groups who are more vulnerable and at greater risk of abuse, such as those with autism, traumatised women and ethnic minorities, and focus needs to be on supporting these people. **LD** stated she would feedback to the Board once scoping of NHSE's National Mental Health Inpatient Quality Improvement Programme is finalised.

4.4 **MC** advised that her priorities were putting measures in place to stopping unnecessary detentions, changing culture and improving data, which is hard to get hold of, to ensure oversight of safety. The DHSC Secretary of State was considering a national review of inpatient services.

4.5 **CP** raised ongoing challenges around police time being taken up by mental health issues, and agreed to meet Minister Caulfield to discuss this further.

4.6 **DC** referenced the recent findings into deaths of three teenage girls in Tees, Esk and Wear NHS Trust and concerns over a culture which meant high levels of restraint were acceptable. She pointed to the need to differentiate between those who died as detained, de facto detained and those who died in the community for lack of mental health care. **DC** raised the need for an independent investigatory body for MHA deaths to perform a similar function to the IOPC and PPO to enable proper collective learning. **MC** advised that all options were open as part of the national review.

4.7 **SF** highlighted that while institutional factors are important, other modifiable factors, such as alcohol misuse and smoking, would make a difference and that early intervention was vital. **KD** reflected that it was important to build on investment for early intervention services such as Liaison and Diversion and that departments could be more ambitious about pushing alternative pathways. **MC** stated that removing police cells and prisons as places of safety is just the start of work in this area.

Action 2: DHSC and NHS England to provide updates on work to prevent deaths on people detained under the Mental Health Act, including on reporting and recording data, at next Board meeting.
Action 3: Minister Caulfield and Minister Philp to discuss issues around policing involvement in responding to people in mental health crisis in the community.

Item 5: An update from the IAPDC

5.1 **JL** highlighted that solutions to prevent deaths did not lie with single departments and that working across boundaries was vital. This reinforced the importance of the MBDC. She asked that the safety of people and protecting lives remain a priority for Ministers.

5.2 **JL** had given evidence to the MHA draft bill, including how there needed to be increased independent oversight of these deaths. Improvements in data collection were needed - there was a longstanding gap between statistics produced by different sources compared to other settings where data is comparable.

5.3 **JL** highlighted some recent Panel priorities. The Panel has been monitoring the aftermath of COVID-19, with prolonged lock-up still having a profound impact on the mental health of prisoners. The Panel has made a data sharing agreement with HMPPS which allows greater transparency of deaths data and data on compassionate release decisions. **JL** was pleased to hear plans were in place for Home Office and DHSC ministers to meet to discuss policing deaths. The IAPDC's report on preventing deaths before, during and after police custody will draw attention to the ways in which local health and policing can work together to reduce time for emergency response - this will be published before the end of November. Regarding immigration, the Panel have sought clarification on public health protocols at the temporary facility at Manston to limit infection spread and protect lives. **JL** was pleased that IAPDC guidelines on suicide prevention have been introduced across immigration removal centres. The Panel's event on suicide prevention in detention was important and endorsed the use of the Ministerial Council on Deaths in Custody's Practitioner and Stakeholder Group, which currently has approximately 200 members. The event was introduced by

Donna Mooney who lost her brother to suicide in prison and was sure that her brother's life could have been saved. A call out to prisoners via Inside Time also elicited some useful responses.

Item 6: Deaths in custody dashboard and key custodial updates

6.1 The **CHAIR** advised that the dashboard includes data on deaths in Approved Premises for the first time. He invited leads for each place of detention to give an update on deaths in custody data and work being undertaken to reduce deaths.

Prisons

6.2 **PC** said that there was a reduction in prison deaths overall, mostly driven by a reduction in natural deaths due to COVID-19 but also due to a slight reduction in the number and rate of self-inflicted deaths which had occurred despite the shortfalls in staffing. HM Inspectorate of Prisons had recently invoked an Urgent Notification at HMP Exeter due to fundamental concerns about safety and high numbers of self-inflicted deaths. Positive work continues on implementing the commitments in the Prison Strategy White Paper. HMPPS is experiencing considerable staffing and capacity issues. There were signs that the position on staffing is beginning to stabilise as numbers of staff leaving fall back and applications increase. The Prison Service Pay Review Body had recommended a substantial increase in pay and there had been good progress on non-pay interventions. The increase in the prison population has been very high recently and HMPPS had taken steps to increase prison supply and activate contingencies. HMPPS had significant concerns about a number of prisons.

6.3 **PD** recognised ongoing good work, though pointed to historic context in the 2010s when a similar imbalance in staff and prison numbers led to increased death rates. He highlighted the acceleration in the prison population since the last Board meeting; the situation had been made worse by changes to the parole system which would result in increasing time spent in custody and remove hope from a large cohort of vulnerable people. **PD** referenced the Justice Select Committee report on IPP prisoners and urged the government to accept its recommendations. **JL** stated that reduced staff support and an increased lack of hope and purpose risked increases in self-harm and self-inflicted deaths. She expressed concern that the remand population has risen significantly and suggested that the courts be guided to use custodial remand only when absolutely necessary and instead consider other restrictions on liberty. **JL** called for the Board to be wise before the event.

6.4 **DAO** stated that the prison population is beyond its buffer, and that IPP prisoners and others could lose the capacity for progression. The **CHAIR** said that the department is consistently discussing these risks and recognises the importance of purposeful activity and progression.

Immigration detention

6.5 **PR** said there had been no deaths in immigration removal centres or residential short-term holding facilities, though there had been a death at the Manston facility over the weekend, details of which they were awaiting. They are also managing shortfalls in staffing and considering safety impact assessments as part of plans to expand the immigration estate.

Police custody

6.6 **RJ** explained that there had been 11 deaths during or following police contact last year, of whom one was BAME, six had mental health concerns and nine had a link to alcohol and/or drugs. Progress had been made in finalising the policing project with the IAPDC, which demonstrated strong examples of local interventions and police and heath partnerships across forces.

6.7 **CP** stated that the composition of deaths in police custody related to either mental health or substance misuse issues highlight the importance of increasing the use of Mental Health Treatment Requirements. They could potentially be used as part of a solution to reduce prolific reoffending.

6.8 **DC** suggested an update on the deaths the IOPC categorise as coming from 'Other' causes at the next meeting. One of the themes for this Board's workplan is on race and disproportionality and DC suggested looking at this in more detail.

Item 7: AOB

7.1 There was no other business.

7.2 The **CHAIR** summarised key actions and thanked attendees for a productive meeting.