Ministerial Board on Deaths in Custody minutes, 13 May 2023

Attendees
Gareth Bacon MP, Parliamentary Under Secretary of State in the Ministry of Justice, Chair *(in place of Edward Argar MP)*

Paul Norris (PN), Deputy Director, Scrutiny, Performance and Engagement, Prison Policy, MoJ
Kathy Smethurst (KS), Deputy Director, Mental Health and Offender Health, DHSC *(also representing Maria Caulfield MP)*
Samantha Newsham (SN), Deputy Head of Police Powers Unit, HO *(also representing Chris Philp MP)*
Frances Hardy (FH), Deputy Director, Detention Services, Immigration Enforcement, (HO)
Michelle Jarman-Howe (MJH), Chief Operating Officer, HM Prison and Probation Service (HMPPS) *(in place of Phil Copple)*
Terence Davies (TD), Deputy Director, Death Management, Inquiries and Coroners, MoJ
Kate Davies (KD), Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England
Fiona Grossick (FG), National Clinical Quality Lead, NHSE
DCC Nev Kemp (NK), Police Lead Custody, National Police Chiefs' Council (NPCC)
Charlie Taylor (CT), Chief Inspector**,** HM Inspectorate of Prisons (HMIP)
Adrian Usher (AU), Prisons and Probation Ombudsman (PPO)
Rachel Watson (RW), Director, Independent Office for Police Conduct (IOPC)
Chris Dzikiti (CD), Director of Mental Health, Care Quality Commission (CQC)
Elisabeth Davies (ED), National Chair, Independent Monitoring Boards (IMBs)
Sherry Ralph (SR), Chief Executive, Independent Custody Visitors Association (ICVA)
Keith Fraser (KF), Chair, Youth Justice Board
Raj Desai (RD), IAPDC
Pauline McCabe (PM), IAPDC
Jake Hard (JH), IAPDC
Andrea Coomber (AC), Chief Executive, Howard League for Penal Reform
Jacqui Morrissey (JM), Assistant Director, Samaritans

For item 2:
Anna Lacey (AL), Deputy Director, Female Offenders and Health Policy, MoJ
Amy Rees (AR), Director General CEO, HMPPS

For item 3:
Jonno McCutcheon (JMc), Deputy Head – Quality Governance, Mental Health, Learning Disability and Autism, and Specialised Commissioning, NHS England

Apologies
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)
Edward Argar MP, Minister of State for Prisons, Parole and Probation, Ministry of Justice (MoJ).
HHJ Thomas Teague QC, Chief Coroner of England and Wales
Martin Jones CBE, Chief Inspector, HM Inspectorate of Probation
Pia Sinha, Chief Executive Officer, Prison Reform Trust (PRT)
Lynn Emslie, Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)
PCC Emily Spurrell, Joint Lead for Mental Health and Custody, Association of Police and Crime Commissioners
Norma Collicott, Assistant Portfolio Director, HM Inspectorate of Constabulary and Fire & Rescue Services

Item 1: Welcome, apologies, actions and minutes

1.1 The **CHAIR** thanked everyone for attending the meeting. He welcomed new members: Martin Jones CBE, the Chief Inspector of HM Inspectorate of Probation; and Rachel Watson, Director General of the Independent Office for Police Conduct. Apologies were received from Chris Philp MP, Maria Caulfield MP, and Edward Argar MP.

1.2 Minutes from the last meeting in October 2023 were approved and circulated with the papers as well a paper updating on actions. The Chair asked that any questions or comments about the minutes and actions be directed to the secretariat. He explained that the dashboard included some unpublished data which should not be shared further.

Item 2: Mental health transfers in prison

2.1 The **CHAIR** introduced the first item on the agenda and explained that HMI Prisons published their thematic review of delays in the transfer of mentally unwell prisoners from prison to secure mental health beds in February this year. **CT** explained the research behind the thematic review, which centred on the delays experienced by acutely and mentally unwell people undergoing severe psychotic experiences. Only 15% of these prisoners were transferred within the recommended 28 days; the average wait was 75 days and 462 days was the longest. Despite the Liaison and Diversion scheme, mentally unwell people were still ending up in prison as a place of safety, and even urgent referrals did not necessarily guarantee a transfer. Prisoners were often placed in segregation units while their condition deteriorated.

2.2 **CT** referenced a case study where a prisoner underwent several assessments and referrals with a total of 234 days spent in a segregation unit and made multiple assaults on staff and instances of self-harm during this time. More generally, poor data quality made it difficult to understand who was waiting and for how long while there was also a lack of accountability and oversight. **CT** did note that there were instances of good practice as well, particularly in London and Bristol. He was concerned about the stalling of the draft Mental Health Bill. He reflected that he felt the NHSE/HMPPS response to the thematic was “disappointing” in that it wasn’t clear what would be delivered, when, and by whom. He also highlighted the lack of reference to bed capacity and general lack of clarity on accountability.

2.3 **ED** explained that the Independent Monitoring Boards published their report on the segregation of men with mental health needs in January, which aligned closely with the report and findings by HMIP. Almost all IMBs had raised concerns about the use of segregation units for prisoners with mental health needs. There was concern among staff that segregation units were often the only option. Prisoners were frequently held for long periods, often moving between different segregation units, making it harder to track the cumulative time spent in segregation. There were lengthy delays in referral assessments and transfers to secure hospitals and the 28-day timeline target was often unmet with frequent reports of people waiting over 100 days, some waiting over 500 days. Assessments were delayed due to disagreements over responsibility and costs, lack of bed availability, and other cases being prioritised.

2.4 **KD** welcomed the report and stated that NHSE had been highlighting this issue for some time. She reflected that there had been an increase in complex needs for this set of patients coming into the prison service over the last 4-5 years, and pointed to a need to focus on sentencing practice as well as to recognise that some individuals will become unwell in custody. She had been engaging with NHSE colleagues to improve the patient pathway; she stated that the 28-day timeframe guidance was published pre-COVID but there have been delays in it being fully implemented. She was disappointed that the draft Mental Health Bill was stalled. **KD** disputed the 15% transfer figure given by HMIP, stating that NHSE data suggested it was closer to 46% meeting the target. **KD** accepted that there was not enough bed capacity, and this was a top priority for the mental health

pathway. NHSE had invested an additional £21m in mental health and neurodiversity pathways across the adult estate and were starting to see some improvements.

2.5 **MJH** recognised that too many people in prison continued to wait too long to access the care they needed in hospital. She noted that there had been some positive work with NHS England colleagues to reduce unnecessary delays and ensure that patients can access care in a timely manner. Key strands of work which are being delivered by MoJ and HMPPS to address the key concerns raised in the report were:

i) Reducing inappropriate remands: this will be achieved through funding a Health and Justice Hub pilot in the Northeast until March 2025 to improve the way that courts, health services and prisons work together to smooth pathways into care, both in hospital and in the community; and by rolling out the Bail Information Service nationwide, helping to ensure judges have the necessary information to make a timely and informed bail decision with confidence.

ii) A commitment to making prisons a safe place to work, providing prison officers with the right support, training, and tools to empower them to do their jobs. HMPPS continued to provide a package of training and support for all prison officers, including training for all new staff on mental health, violence, self-harm and suicide. The staffing position had improved significantly over the past 12 months, but this had created a level of inexperience in prisons, and a high number of staff were currently undertaking training which was creating further staffing gaps. For those at risk of self-harm and suicide, HMPPS provided individualised support through a multidisciplinary case management process which places a strong emphasis on identifying individual risks, triggers and protective factors and having effective care plans in place to record, address and mitigate risks. This included prisoners with a mental health need or who were awaiting transfer. Assessments were multidisciplinary and involved contributions from healthcare staff and other relevant stakeholders (for example, substance misuse and mental health teams) as appropriate.

2.6 **MJH** stated that HMPPS recognised the need for better Management Information on incidents involving those with a mental health need or awaiting transfer to hospital under the Mental Health Act. **AR** offered to follow up with Kate Davies and Michelle Jarman Howe, to understand the data and the impact on extremely unwell prisoners of the capacity challenges.

Action 1: HMPPS and NHSE to meet to understand data and the capacity impact on the most complex MHA transfer cases.

2.7 **AL** acknowledged that HMPPS were working closely with health partners to strengthen oversight to improve timeliness. In the absence of the Mental Health Act Bill, this included driving forward work to introduce a non-statutory independent role designed to improve oversight and monitor delivery of the 28-day time limit for transfers set out in NHS England's good practice guidance.

Item 3: Early Warning Signs of serious quality and safety issues in mental health inpatient units

3.1 **JMc** explained that this piece of work arose from a finding in the DHSC Rapid Review into the safety of mental health inpatients; one of the recommendations was the establishment of a programme of work to ensure that providers, commissioners, and national bodies were 'measuring what matters' for mental health inpatient services. This work is embedded in a wider programme of work focussing on the models of care, with the aim of exploring and accelerating more therapeutic models. The same programme is focussing on the culture of care within inpatient services - prioritising the relationship between staff and patients, and work to make governance arrangements

more sustainable and transparent. Reducing restrictive interventions across all inpatient settings is an underpinning theme. In developing the 'metrics that matter', or 'Early Warning Signs', NHS England have engaged with over 200 people across the country – including patients, families and staff.

3.2 The next step is to identify quantifiable data which align with the warning signs, recognising the real value in any Early Warning System is not just the data, but the soft intelligence and discussions they provoke. NHSE were aiming to identify examples of "soft intelligence" which drew on the views of partners, and that people should be looking out for. **JMc** noted that it was important to recognise that warning signs alone cannot determine the performance of a particular Trust, and that further work will be needed to identify who was responsible for reviewing Early Warning Signs and how**.**

3.3 **KS** advised that DHSC had been working closely with NHSE on the issues raised in the Rapid Review. One of the actions from the Review was to look at data on mortality from various sources, including CQC and the Office for National Statistics. The first meeting of the working group, chaired by Louis Appleby, had taken place and Lynn Emslie and Seena Fazel from the IAPDC had both attended. The group were looking at data on all deaths, where the gaps were, what the flow of that data was when a death occurred and what action it led to in learning and making improvements – this was a complementary piece of work which would feed into the early warning signs programme.

3.4 **DC** noted that a number of recent inquests had raised concerns about safety and culture in mental health settings and urged DHSC and others to look at the verdicts and Preventing Future Death (PFD) reports which provided good insight. She asked about the work on the use of force in mental health units and key elements of the MHA about the importance of culture that had not been implemented. **JMc** referenced the Reducing Restrictive Practices Oversight Group (RRPOG) which would identify and share learning, and the Culture of Care programme which is being used to embed learning from the RRPOG. **ED** wondered how data would be used to account for the existing power imbalance between activity metrics, and the voices of staff and patients. **JMc** stated that it should be equally balanced between the voices of patients, staff and carers, and the data. The dashboard will not be the solution, but the trigger for a conversation about lived experience which is the most important indicator of the quality of care.

Item 4: Independent Advisory Panel on Deaths in Custody update

4.1 **RD** explained that the Panel had published its work priorities for 2024-2025 and iterated that the Panel was well-placed to work closely, flexibly and collaboratively with co-sponsors, including meaningfully informing decision-making at a formative stage. **RD** reflected on the position of acutely mentally unwell persons in prison and the current absence of timely access to treatment which gave rise to serious and unacceptable risks to the safety of these prisoners and to the staff attempting to care for them in impossible circumstances. The Panel's work on identifying the characteristics and structure of an independent body to investigate deaths in MHA detention was underway, and a proposal will be brought forward in due course.

4.2 **PM** noted that the latest Prison Safety Statistics reported a welcomed decrease in overall deaths, but also showed no reduction in deaths by suicide and an increase in the rate of self-harm as well as an increase to assaults on staff. These figures compounded serious concerns about the impact of overcrowding on prisoner safety, which were stated unequivocally by the Special Rapporteur in his 2023 report[1] into what he called the *"largely preventable, silent global tragedy of*

[1] Deaths in prison report of the Special Rapporteur. April 2023. A/HRC/53/29: Deaths in prisons Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Morris Tidball-Binz | OHCHR

deaths in custody." The action taken by HMIP in raising an Urgent Notification at HMP Wandsworth recently resonated with the Rapporteur's warning.

4.3 The Panel had raised concerns both about risks arising from the capacity mitigation measures forced by the over-crowding crisis, and the impact on prisons. Examples of the mitigation concerns included:

- The outworking of the Probation Reset, including the bar for final third probation input being limited to "*those at very high risk of serious self-harm"*;
- The impact on the adequacy of arrangements for the resettlement of vulnerable inmates, and of the extension of the End of Custody Supervised License, which was being increased to 70 days;
- The decision to extend the interim policy decision to retain more over-18-year-olds in the youth custody estate. In the year 2022/2023, levels of violence in the estate rose by 25% and levels of self-harm by 33%. Reports from HMIP and other oversight bodies and stakeholders raised concerns about children spending up to 23 hours a day alone in cells.

4.4 **PM** stated that even if over-18's could be accommodated in youth custody, the additional pressure on resources and services could not be in the best interests of the young people currently detained and that there should be no further extensions of this arrangement. This was all the more important as the number of children in custody was expected to rise as a result of increased police recruitment, moves to tackle the court backlog caused by Covid and tougher sentencing.

4.5 **PM** stated that overcrowding affected the capacity, timeliness and quality of individual offender access to time out of cell, purposeful rehabilitative activity, key worker contact, and access to health, mental health, addiction and other therapeutic programmes. The central role of purposeful activity, time out of cell and access to health services in keeping prisoners safe was well understood. The Panel welcomed efforts to try to improve regime availability and access via the National Regime Model and had shared feedback and suggestions with senior leaders, including at the MBDC Implementation Group. However, the Model was based around the "best possible outcomes achievable," and often the minimum standards fell far below what was needed. Examples included the minimum requirement for just one key worker one-to-one meeting per month, and a minimum of just two hours out of cell time each day, including the mandatory one hour in the fresh air. The Panel advised that progress towards best practice informed acceptable service delivery standards was urgently needed moving forward. The Panel would continue to support all efforts to address and mitigate the effects of overcrowding, which was fundamental to keeping prisoners safe.

4.6 **PM** explained that average sentence lengths had increased and prison numbers were forecasted to rise to 114,800 by March 2028, therefore a longer-term strategy was urgently needed as well as a step-change in policy-making processes. On the presumption of community sentences under 12 months, the Panel welcomed the measures in the Sentencing Bill to help low risk offenders avoid repeated short prison terms and turn their lives away from crime, whilst easing pressure on prison capacity, although this would have a relatively modest impact on capacity pressures. However, prisoners on short sentences placed considerable and disproportionate demands on prison committal processes and physical and mental health, addiction and other services and the Panel welcomed that a reduction in numbers could be expected to yield a disproportionate benefit for service delivery. It was important to note that these offenders may become more vulnerable to self-harm and suicide in the community whilst on a suspended sentence.

4.7 The Panel was concerned to read the probation inspection report of Kent, Surrey and Sussex, and the concerns around managing people on probation and the findings about the poor quality of court reports. The Panel welcomed assurances by Minister Caulfield of the 82% availability of mental health provision across all criminal courts in England with 100% coverage expected by the end of 2024, but remained concerned about offender safety risks due to gaps in probation capacity and Community Sentence Treatment Requirement availability and resourcing, as well as the preparedness to meet the expected increase in demand.

4.8 The Panel wrote to Minister Agar and Minister Caulfield emphasising the importance of delivering probation reports and supervision, and comprehensive access to drug, alcohol, mental healthcare, and other community support, that will keep those given suspended sentences safe, and were pleased that these had been included as a focus for action in the 2024/25 Ministerial Board workplan.

4.9 **RD** stated that the link between capacity pressures and safety was not unique to prisons. Ministers and officials must have defined and robust processes to understand, with sufficient precision, the likely impact of their decisions on the prison population, to take account of the safety implications of increases in numbers for prisoners and staff, and to proactively identify necessary action to mitigate adverse safety impacts resulting from these increases. The current arrangements for forecasting the impact of new initiatives on prisoner numbers were not adequate. The Panel were undertaking further research into practices on capacity modelling and would report back in due course.

4.10 There was a need for enhanced processes to ensure that the safety implications of decisions were fully identified and placed at the heart of the decision-making process. The Panel recommended the Safety Impact Assessment methodology – adopted by HMPPS in 2021 to assess the safety implications of its "large change programmes" and amendments to its policy frameworks – as a useful existing framework for this. The Panel pushed for a Ministerial commitment to the establishment of a non-negotiable decision-making red line that custody numbers would never be permitted to exceed safe capacity. This red line must be backed by robust processes to enable the implications of decisions impacting on prison numbers to be understood, and to enable all necessary action to ensure prisoner and staff safety to be proactively taken.

4.11 **KF** referenced the Panel's statistical analysis report, noted the disproportionality of different ethnic groups and differences in quality of the data and asked what was being done to address this. He would support work to argue for a discrete approach to children and young people but worried that the increase in police numbers would lead to a rise in the numbers of children coming into custody. **RD** explained that the Panel were planning to work with the IOPC to look at the issue of disproportionality.

Item 5: Deaths in custody dashboard and key custodial updates

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

<u>Prisons</u>

5.2 **MJH** noted that the prison population remained around 99% of Usable Operational Capacity and that this was being addressed by maximising use of the Category D estate, the use of the End of Custody Supervised License and maximising use of Home Detention Curfew to ensure they could maintain sufficient capacity across the estate. HMPPS had some red lines including around crowding, staffing, and critical maintenance of the estate. **MJH** recognised that they wanted to go further with the National Regime Model and had pushed governors to take ownership and set a level of ambition around regime, keywork and staff capability, all aimed at making prisons safer.

<u>Immigration detention</u>

5.3 **FH** noted that deaths remained very low with one self-inflicted death in an Immigration Removal Centre and one death following release. There had been an increase in self-harm though there was no direct correlation to self-inflicted deaths and HO were working on understanding the data. They were expanding support from the Samaritans for those arriving in detention, doing some

work on near-misses including a review of personal items which may pose a safety risk, and on the use of the Assessment Care in Detention and Teamwork process across the estate. FH thanked IAPDC members for all of their support with work to reduce deaths in immigration detention.

Police custody

5.4 **SN** explained there were 23 deaths in 2022/23 and 15 deaths so far in 2024 and noted that numbers were higher than in previous years. Operation Safeguard had been reactivated with 179 police cells in use. Work on the Association of Police and Crime Commissioners' guidance on deaths in custody was compete and would be circulated, and the Home Office had provided a grant to support this work. They continued to work with the National Police Chief's Council and College of Policing on post-custody suicides and had expanded their data collection on deaths in custody.

Detention under the Mental Health Act

5.5 **KS** stated that there had been a slight reduction in deaths, though numbers still remained high. CQC had not been able to carry out an analysis to understand if the reduction was significant. Use of restraint did not appear to be the cause of any of the deaths. The Mortality Data Working Group met the previous week to look at lag time on data and quality. The Health Services Safety Investigations Body were making good progress with their investigations into patient safety, the CQC was reviewing their mental health mortality data and how it could be strengthened, including on how gaps could be addressed, and learning was maximised. KS noted that DHSC had published a response to the pre-legislative scrutiny report on the draft Mental Health Bill in March.

5.6 **KD** stated that NHSE were constantly responding to systems, screening and assessments for all custody sectors. The women's population was also high and 70% of all prisoners were having drug and alcohol assessments alongside mental health. Health services were also being impacted by the staffing and capacity issues.

5.7 **PM** pointed to the Panel's joint event with NPCC earlier in the year and the identified areas for key learning and stated that re-instating Operation Safeguard was not an ideal situation. **ED** wondered whether, due to the issues with staffing, there were enough health qualified staff in IRCs and prisons. **KD** said that partnership agreements dictated staffing requirements but could not confirm whether it was enough, and that agreements were based on a static estate, not the current churn. **NK** explained that Operation Safeguard was a temporary measure. He was concerned that government were addressing prison capacity issues with only two options – adjusting the number of prison places or enacting Operation Early Dawn (an emergency measure to assess each morning which defendants can be transferred from police cells and taken to courts to ensure there is a safe and secure location if they are remanded in custody). He had written to Minister Philp highlighting the need for a long-term sustainable plan.

Item 6: AOB

6.1 There was no other business.

6.2 The **Chair** advised that the next Board meeting would take place in October 2024, date to be confirmed. He asked that Board members let the Secretariat know their suggestions for potential items for the next Ministerial Board meeting. He reiterated the only action from the meeting was for HMPPS and NHSE to work to understand the capacity impact on the most vulnerable prisoners.

6.3 **DC** referenced an historic ruling relating to an unlawful killing in HMP Woodhill and cited the failure to enact recommendations made following previous deaths. She asked that the next Ministerial Board meeting should focus on the Panel's Preventing Future Deaths report and Inquest's National Oversight Mechanism report. **PN** requested that this be discussed away from the meeting.

6.4 **KS** added that Minister Caulfield would like it noted that the Suicide Prevention Strategy includes an ongoing action for the MoJ to roll out ligature resistant cells for high security prisoners and that Minister Caufield wanted to lend her support for rolling out these cells.

Date of next meeting: October 2024 tbc