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

Ministerial Board on Deaths in Custody minutes, 26 November 2024

Attendees

Lord Timpson OBE (Chair), Minister of State for Prisons, Probation and Reducing Reoffending, Ministry of Justice (MoJ)
Dame Diana Johnson DBE MP (DJ), Minister for Policing, Fire and Crime Prevention, Home Office
Baroness Merron (BM), Parliamentary Under Secretary of State for Patient Safety, Women's Health and Mental Health, Department of Health and Social Care (DHSC)

Paul Norris (PN), Deputy Director, Scrutiny, Performance and Engagement, Prison Policy, MoJ
Kathy Smethurst (KS), Deputy Director, Mental Health and Offender Health, DHSC
Samantha Newsham (SN), Deputy Head of Police Powers Unit, HO
Frances Hardy (FH), Deputy Director, Detention Services, Immigration Enforcement, (HO)
Phil Copple (PC), Director General Operations, HM Prison and Probation Service (HMPPS)
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, NHS England
Sarah Warmington (SW), Head of Mental Health, NHS England
HHJ Alexia Durran KC (AD), Chief Coroner
Simon Barnes (SB), Staff Officer for ACC Balhatchet**,** National Police Chiefs' Council (NPCC)
Charlie Taylor (CT), Chief Inspector**,** HM Inspectorate of Prisons (HMIP)
Kate Green (KG), Association of Police and Crime Commissioners (APCC)
Adrian Usher (AU), Prisons and Probation Ombudsman (PPO)
Amanda Rowe (AR), Director of Operations, Independent Office for Police Conduct (IOPC) *(for Rachel Watson)*
Laura Baker (LB), Deputy Director, Care Quality Commission (CQC) *(for Jenny Wilkes)*
Arabella Hoskyns (AH), Head of Policy and Impact, Independent Monitoring Boards (IMBs) *(for Elisabeth Davies)*
Sherry Ralph (SR), Chief Executive, Independent Custody Visitors Association (ICVA)
Alex Hewson (AHe), Senior Policy and Communications Officer, Prison Reform Trust (PRT) *(for Pia Sinha)*
Deborah Coles (DC), Executive Director, INQUEST
Norma Collicott (NC), Assistant Portfolio Director, HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)
Lynn Emslie (LE), Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)
Jake Hard (JH), IAPDC
Seena Fazel (SF), IAPDC
Andrea Coomber (AC), Chief Executive, Howard League for Penal Reform
Julie Bentley (JB), CEO, Samaritans *(for Jacqui Morrissey)*

Apologies

Martin Jones CBE, Chief Inspector, HM Inspectorate of Probation
Keith Fraser, Chair, Youth Justice Board

Item 1: Welcome, apologies, actions and minutes

1.1 The **Chair** thanked everyone for attending the meeting. He welcomed new members Ivan Balhatchet from the National Police Chiefs' Council; Kate Green from the Association of Police and Crime Commissioners; Chief Coroner Her Honour Judge Alexia Durran; and Jenny Wilkes, interim Director of Mental Health at the Care Quality Commission.

1.2 The **Chair** explained that he received information whenever a death occurred in prison although he did not receive details of all other incidents, such as self-harm. It was important to remember the impact of deaths on staff, family, friends and loved ones. He updated on deaths which occur in prisons and other MoJ custodial establishments and referred to a recent death in an Ellesmere Port Approved Premises, where he had spoken to staff about the impact of the death on them. He noted the increase in deaths in police custody from the average 19 to 24, the 68 apparent suicides in the 48 hours after release, and two deaths in immigration removal centres and stated that it was easy to look at these as numbers, but they were real people with families and friends. He was interested to hear what could be done to reduce these numbers. He noted that many die at too young an age: the average age of someone dying in the community is 82 but the average age that someone dies in prison is 56 for men and 47 for women.

1.3 Minutes from the last meeting in May 2024 were approved and circulated with today's papers. The **Chair** asked that any questions or comments about the minutes and actions be directed to the Secretariat.

Item 2: MBDC priorities for next year and beyond

2.1 **PN** explained that this first Board with a new government was an opportunity to work towards setting a new workplan and to use this discussion to create a forward look on items to bring to future meetings to ensure Ministers can drive action. He explained that the consultation exercise conducted prior to the meeting on future Board priorities had 15 responses covering a range of issues: (i) prison capacity; (ii) data; (iii) mental health care provision; (iv) isolation; (v) children in custody; (vi) identification and management of risk factors and information sharing; (vii) substance misuse; (viii) use of force; (ix) workforce; (x) sentencing; (xi) research; (xii) emergency response and evacuation procedures; and (xiii) investigations and learning. The most popular suggestion was mental health provision, followed by identification and management of risk factors. It was important to look at how to drill down into the detail and how the Board could direct activity to reduce deaths across all custodial areas.

2.2 **DC** apologised for not responding to the consultation. She welcomed the Chair's comments about the impact of deaths in custody and was particularly interested in the experience of families following a death and the importance of the inquest process in drawing attention to failings. She supported doing more work on investigations and learning; previous Boards had looked at reviews conducted into deaths of women, children and young people, and police custody where a series of recommendations had been made but not followed through. She was frustrated by the continued desire for more data as the Board had evidence from successions of government reviews and oversight and monitoring boards and wanted to turn the focus to the human stories, to identify where things had gone wrong in more meaningful ways than just the data. She asked to add this to the list.

2.3 **KD** suggested that a two-pronged attack by the Board was needed to look at larger strategic and policy items. The Mental Health Bill and the Independent Sentencing Review were both important to ensure people were in the right place, that prison was not being used as a place of safety and thinking particularly of the large numbers of remand and IPP prisoners still being held. There was discussion of many agendas from members but if the Board could aim to get one or two things right it could lead to change. There needed to be a focus on how mortality rates, deaths in custody, and self-harm can be a part of the health and justice space and a health and wellbeing position as well. She reflected that she has been a part of the MBDC for a long time and it is a good cross-departmental group, but needed to be right. The **Chair** commented that he is keen to focus on things that really work and can be effectively prioritised.

2.4 **KG** stated the average age for deaths in prison was genuinely shocking. She questioned the need to lock up very elderly people as the aging population was an issue. She noted the substantial increases in recruitment in prisons and the police which was welcome, but this was a young, inexperienced workforce for whom the pressures of what they were dealing with could be quite overwhelming. If the Board was to focus on areas that may make a difference, equipping the workforce with training and support and ensuring that all workforces are properly equipped to identify risk factors and the appropriate action should be a priority.

2.5 **AHe** agreed and added it was important to focus on fundamental issues in prisons that can be resolved with quick wins. This was a key challenge and the Prison Reform Trust had raised it with Prisoner Advice and Care Trust (PACT) on the use of safer custody hotlines. One issue has been the increase in calls from individuals in acute distress or crisis and relaying those concerns in a safe and timely manner so that welfare checks can be made. But this is an area where it is within the ability of prisons to drive improvements. It is right to think that lessons can be learned from fatal incidents reports but there are some basics that require what **KG** was suggesting, for instance, upskilling the workforce to ensure the very basic things work effectively. Preventative factors to focus on are prison regimes – ensuring people are out of their cells more than two hours a day, employment and education and other purposeful activity – to drive down some of the causes of decline in wellbeing amongst people in prison. He also wanted to raise PRT's work on its Building Futures programme for long sentences in custody, and the recently published report on maintaining family contact and the impact of isolation.

2.6 **AU** agreed that services must never forget there are real people behind every statistic. He speaks to every family of prisoners who complete suicide in prison and could not agree that the work should not be data driven. The two biggest themes emerging from PPO investigations are mental health and isolation; there is a great deal of data available on these but there is a question as to whether it is working towards making a difference. Incarceration should not mean isolation. **SF** was pleased to see use of data and research being prioritised and agreed that better use could be made of data. However, there are hierarchies of evidence and different ways in which evidence can inform best practice. If one looks at what drives down death rates in the community – infectious diseases rarely kill, amazing strides have been made in cancer and cardiovascular treatment – this is derived from data, trials, and testing interventions. These improvements do not come from simply speaking to people though this can complement the data.

2.7 **JB** stated that the two areas to concentrate on are mental health screening on entry into prison and knowledge and skill of the workforce to deal with suicides. Many people struggle to talk about these things, leading to tensions in the workforce, loss of experienced

people, and problems in how to recognise suicidal ideation. **BM** noted that this discussion of priorities was important, but the issues raised have been very broad and will require further scoping to become focussed priorities that can deliver results. She noted that suicide prevention is within her portfolio; she is committed to the National Suicide Prevention Strategy but would like to see where it can be taken further. She would also like to see dying by suicide as a priority under risk identification and management. The Mental Health Bill received its Second Reading in the House of Lords, and she noted she was pleased with the discussion and wished to thank those who contributed. Government will be updating the Mental Health Act (MHA) code of practice once the Bill becomes an Act, with a formal consultation on the code. She noted the point about not using prisons and police cells as places of safety, but the challenge lay in provision that will then need to be made. She noted that she and the **Chair** are very aware of that need.

2.8 **AC** stated that their priorities were also mental health and isolation, but that by the time an individual in custody started talking about mental health it was already too late. The focus needed to be on earlier intervention and diversion. Prison provides a damaging environment for those with mental ill health. The Sentencing Review provides an opportunity to focus on diversion away from custody and asked Ministers to keep this in mind when considering what may be politically deliverable. She raised the question of who goes to prison for how long: looking at the data dashboard for this meeting, she suggested that nearly 100 deaths would be avoided if individuals over 70 were not imprisoned, with 29 deaths between the age bracket of 80 and 89 alone. She asked which priorities of sentencing are being met in imprisoning such people.

2.9 **SR** welcomed the Mental Health Bill but noted the need to keep a watching brief on the unintended consequences of banning police cells as a place of safety, such as individuals being arrested for breach of the peace but with nowhere to hold them after an arrest under section 136 MHA. She also noted the importance of tracking people through the criminal justice system: the point at which they reach police custody is too late; diversion needs to be in place for those who are mentally unwell. She also noted the risks of people being over-assessed: those in detention are sometimes asked the same questions again and again, which can lead them to becoming fatigued or triggered. More effective information sharing can help ensure these are less traumatic.

2.10 **SB** explained that Ivan Balhatchet had recently taken over the NPCC custody portfolio but could not attend and sends his apologies. They will be setting up a regional working group with a focus on the safety of detainees and staff in the custody environment. He noted the high level of deaths in police custody and the strong correlation between those who had died and mental health issues. NPCC will be looking into the risk assessment process of those coming into custody, how it can be improved, and how to better share information – for example, with NHSE to better understand individuals' ill-health before they arrive in custody.

2.11 The **Chair** noted that family support was very relevant and that the Building Futures work was excellent. The MH Bill had a lot of relevant avenues to return to as did the Sentencing Review – he assumed that attendees had seen the call for evidence and invited them to provide submissions. On workforce, he invited **PC** to update on this, noting that he did a review of prison officer training before he took on his current role. He found that it was not just about unlocking gates but human relationships and trust. He stated his interest in data around improvements to cancer and disease deaths, and in early diversion away from prison, noting the connections with the Sentencing Review.

Action 1: Prison Reform Trust to share their Building Futures report, and report on maintaining family contact, with MBDC members.

Action 2: MBDC members to identify and agree specific actions for inclusion in the workplan at a meeting of the Implementation Group in 2025.

Action 3: Seena Fazel to share learning on use of data to tackle infectious diseases and cancers (as an example of how custody settings should be using data-driven learning to bring down custody deaths).

Action 4: DHSC to provide an update to MBDC on their upcoming consultation to update the Mental Health Act Code of Practice.

Action 5: NPCC to provide an update on their regional working group to focus on the safety of detainees and staff in the custody environment.

Item 3: Sharing learning on reducing deaths by ligature points

3.1 The **Chair** noted the numbers of deaths by ligatures included in the accompanying paper and stated his desire to hear insights, learning, and positive practices we can put in place to dramatically reduce this number.

3.2 **PN** noted the large proportion of self-inflicted deaths in prison custody and Mental Health detention relating to ligatures. The majority of deaths were now from low lying ligatures but there was no room for complacency on higher ones as there were still 14 deaths in 2023 involving wall mounts and fittings in prisons. This discussion was to identify the biggest opportunities and challenges in this area which will be followed up in more detail at a future MBDC policy forum in the new year. He asked to hear members' views on what should be prioritised from the suggested key themes:

- Challenges and practicalities in removing ligature risks;
- Identifying risks through regular audits;
- Addressing the biggest risks to reduce immediate harms;
- Decency and dignity versus safety;
- The role of therapeutic environment and relationships;
- Data, learning, and research;
- What role for a national strategy?

3.3 **PC** stated there was much evidence to suggest that making the environment more ligature resistant has a positive impact, but the challenge lay in maintaining standards. The use of windows as ligature points has gone down, as an example, having gradually been changed across the estate although low-lying ones can still be used. The service had tried to identify funding to create a network of safer cells across the estate, targeted at higher risk institutions in terms of population with a view to maintaining them as safe cells. New builds and refurbishments incorporate safer standards but also involve a trade-off between safety and dignity and cannot absolutely guarantee safety. The service needed to be mindful of financial constraints as well. There was a programme to create 52 safer cells across 13 sites with a possible further tranche in 2025/26, averaging at £50,000 per cell. Operationally, they were also trying to identify prisoners at higher risk.

3.4 **FH** stated that immigration detention had similar issues. Although there had been only one self-inflicted death over the last 12 months, there had been a number of near misses. They had undertaken a Lessons Learned Review (LLR) for each of these with the

overriding concern of how to balance decency and dignity with security, for instance, in managing possessions and removing clothing without impacting on wellbeing. These were currently managed via individual risk assessment. However, she was interested to see what learning there may be across other custody settings to manage these risks.

3.5 **CT** said that large numbers of people who take their own lives had not been identified as a risk by staff and were not being picked up because staff did not know what to look for, the systems may not be effective, or prisoners arrive very late at night and healthcare staff are not available. Creating safer cells was part of the issue but undertaking proper assessments of individuals coming into custody was key. **SB** noted the need to focus on ligatures but agreed that risk assessment of vulnerable people very early was needed. He noted that even if all ligature points are removed, people can still find ways of taking their own life.

3.6 **JB** agreed with the list of priorities. She noted that reducing access was very difficult, particularly balancing dignity and saving life. She wondered whether affected populations in prisons had been consulted for their views or whether any international comparisons had been done. **SF** referenced the Panel's interest in this area and welcomed it being highlighted. He noted that successful suicide prevention in the community was focused on reducing access to means, so this should be central to the discussion. He asked whether there was a national strategy relating to reducing ligature points rather than leaving the decision to individual governors, giving as an example that there had been one death from wall fittings in 2022 but this figure went up to 14 in 2023, suggesting the need for a national approach. **JH** asked if there was an opportunity to consider people being incarcerated in the Sentencing Review and what can be learned from the international community about suicides across Europe. Other countries had seen prisons with much greater levels of ligatures but lower suicide rates and suggested this indicated the need for focus on the individuals and their specific risks.

3.7 **KD** stated that people can deteriorate significantly while in custody. Better screening within 24 hours and seven days of receipt into custody had seen improvements, but key to wellbeing was free movement and access to peers. The lived experience perspective was clear that freedom of movement is important, as is the case in the women's estate. With new prisons, she noted that it can appear difficult to get the prioritisation right with considerations of cost, size, and other practicalities. She reported her experience visiting HMP Millsike and identifying ligature points in its health and wellbeing units that should not have been there. **DC** stated that institutional culture may be the issue; when an individual with no history of self-harm enters prisons and starts to display suicidal behaviours, this may be the institutional cultural impact of isolation and segregation. She agreed with the Samaritans about talking to those affected; Listeners have a strong evidence base for what is a healthy prison and likewise for some mental health settings.

3.8 **PC** explained there was a national strategy regarding window replacement, but the pace was not what it ought to be. This was partly due to funding constraints though the service was trying to accelerate major works. Windows are also important within the context of illicit substances entering the estate. A presentation from Professor Louis Appleby to the Board several years ago had suggested that in every prison system, most people who complete suicide were not identified as at risk. General contextual factors, the psychological environment, and the ability to talk to people are all important. Many people who could take their lives do not do so, so the impact of protective factors is unclear. But he agreed that work on reducing access to means is important to take forward.

3.9 **SR** stated that suicide in police custody is low. The ICVA had been working on anti-rip clothing and how people are being forced into it in police custody and would be happy to talk about the learning from this at a future meeting. **JB** noted terminology in this area – the need to use the term “suicide” and that people “died from” rather than “committed”.

3.10 **PN** summarised some of the main themes: reducing means of ligatures although it was difficult to achieve, the Sentencing Review and who is held in custody, and international comparisons. The **Chair** added that a lot of people attempt suicide but that how they are identified and how people deteriorate in custodial environments needed to be look at more closely.

Action 6: Secretariat to produce a paper on sharing learning on reducing deaths by ligature with MBDC members ahead of the 2025 Policy Forum on this subject.

Item 4: Independent Advisory Panel on Deaths in Custody update

4.1 **LE** stated that the conversations taking place at the Board align closely with those of the IAPDC. This was the first meeting of the Board with the new government and ministers and presented an opportunity for strategic and joined up working that is aligned, priority focused, and used learning for long term planning. It was important to ensure the Ministerial Board workplan was tied to the delivery of safe detention. The IAPDC workplan for 2025 will focus on key areas of prison challenges and impact on purposeful activity, ACCT, prison staff training; MHA detention deaths and need for robust data to support work as outlined in findings from the NHSE Rapid Review; to build on evidence produced in the statistical analysis; Approved Premises and children in custody; deaths within 48 hours of release from police custody, and proposals to independently investigate deaths under the MHA. On post-police custody deaths, the Panel have partnered with the NPCC to produce good practice guidance, and stakeholders had agreed to explore the potential local support partnerships. This work was progressing and in June 2024, the APCC produced guidance on deaths in police custody, developed with the Panel following recommendations from their report.

4.2 **JH** wanted to raise the issue of investigations under the MHA which were not currently subject to automatic independent investigation in line with Article 2 principles in contrast with other places of detention. This was raised many years ago in 2004 in a JCHR report. The mortality rate in this setting was significantly higher than in other places of detention. The lack of high quality and timely data to help with understanding these deaths hindered further learning. The Panel will bring a paper to the next meeting setting out research and recommendations as to how an independent body could be established to investigate these deaths.

4.3 **SF** noted that England and Wales had one of the best data sets in the world to study risk factors for suicide and natural cause mortality and can lead in this area internationally. There was a need for dedicated funding streams for research, and currently these did not exist. There was a tendency in this area for people to “mark their own homework”. Processes for carrying out research in prisons was very difficult, unlike in NHSE who take six weeks to do a review, but HMPPS committees take in excess of a year.

4.4 **DJ** welcomed the Panel’s work with the NPCC and CoP around the risk of suicide following release from police custody. The Home Secretary had been talking about police

reform, there was best practice in some police forces, but this may not be happening in all forces, so getting that consistency was part of this reform, as was the availability and quality of data. The White Paper will be published in the spring.

4.5 **KG** noted the consultation by HMICFRS on mainstreaming custody inspections and asked that Ministers did not lose focus of what previous custody inspections had raised. **SW** noted that MHA detention deaths did not just happen in secure hospitals, 50% from prisons go to psychiatric units and adult acute wards commissioned by Integrated Care Boards.

Action 7: IAPDC to finalise report on MHA deaths investigations, consult with MBDC members as appropriate, and present its findings and recommendations at the next MBDC meeting.

Action 8: Seena Fazel to write to Minister Timpson about the National Research Council – *complete*.

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.

Immigration detention

5.2 **FH** noted that in the past 12 months, there were two deaths in immigration detention and one shortly after release, with inquests expected in spring next year. Self-harm and near miss incidents remained low – less than 0.1% of an arriving detention population of 18,000. They have prioritised learning from near-misses via internal processes to ensure meaningful change, such as LLRs after a near miss. As a result, they had changed their approach and guidance on razorblades, use of TV brackets, and safeguarding bulletins guidance to IRCs on constant observations and management of personal items used in suicide and self harm – all learning derived from inquests, third parties, and LLRs. **FH** was grateful to the IAPDC, particularly **JH**, who had provided independence and rigour to their processes. Next steps were to review the Adults at Risk policy and Rules 34 and 35, ensuring vulnerable individuals are brought to the attention of those authorising detention, and a review of policy and provisions in place for those who lack mental capacity which will take place next spring.

Police custody

5.3 **SN** explained there were 24 deaths in or following police custody, an increase of one, and the highest level for 17 years. 19 of those who died had mental health concerns and 21 had link to alcohol or drugs. The College of Policing will be establishing a database to ensure learning is incorporated into training and guidance. She noted the work with the IAPDC on post custody suicides and that the ICVA are developing training resources on suicide prevention awareness. The APCC guidance on preventing deaths was published in June and will remain under review to monitor impact.

Detention under the MHA

5.4 **KS** stated that CQC had been informed of 288 deaths in the 12 months to March 2024. Natural deaths were now broadly at the level they were before COVID, but there had been an increase in non-natural causes. CQC had not completed analysis of whether this

change was statistically significant, but it is a reasonable conclusion and the numbers remain too high. Of the 13 deaths involving restraint, in one case restraint was thought to have exacerbated heart disease; an update on this will be provided to the Board. On developing data, the Minister has decided to re-establish the Rapid Review Mortality Data Working Group and DHSC officials have started taking steps in this direction. NHSE continue to progress work on early warning signs which were being piloted in integrated care boards (with the aim to get them up and running in 2025/26). **KS** offered to present learning from the pilots to the next Board. CQC had completed the first phase of their project on notifications of deaths, although the work was paused while they sought to make improvements to operational delivery.

Prisons

5.5 **PC** noted there were many contextual factors which cause difficulty in understanding rates of self-inflicted deaths. There may have been an expectation that the increase in remand and recalls, for instance, would affect rates of deaths but the numbers were slightly down from the last 12 months. Similarly, the End of Custody Supervised License scheme might have expected to be unhelpful in reducing deaths post-release, but the service continued to have the same number but at a slightly lower rate. Significant challenges remained in terms of other contextual factors such as drugs, purposeful activity, and development of key work. Staffing was also a challenge, and they were trying to raise capability and confidence of staff through training, with nearly a third having less than 3 years' experience. There is a new operational policy framework for safety, with incorporated learning from deaths and inquests. **PC** also expressed his gratitude for the input they received from a range of stakeholders including the IAPDC. There was also further work on strengthening family liaison and emergency responses.

Action 9: Home Office Detention Services to provide an update on the latest developments in their reviews to the Adults at Risk policy and Detention Centre Rules 34 and 35 and also to provide information about their planned review of policy and provisions in place on mental capacity.

Action 10: Home Office to connect MBDC secretariat with the Police Performance Unit, once established, to share information and enable input from the MBDC.

Action 11: DHSC to provide an update to IAPDC and other relevant MBDC members on reopening the Mortality data working group.

Action 12: CQC to provide an update on the latest developments in the Mortality Review (including on improvements to deaths notification data) and on the outcome of their review of the case involving restraint described during the meeting.

Action 13: DHSC to engage NHSE about providing an update on the early warning signs pilot at a future MBDC meeting.

Item 6: AOB

6.1 The **Chair** advised that the next Board meeting will take place in Spring 2025, date to be confirmed.

6.2 **CT** expressed concern that the custodial updates item at the end of the meeting does not allow time for discussion. The **Chair** agreed to take note.

6.3 The **Chair** stated that **DJ** will chair the next Board meeting and **BM** the following one.

6.4 **DC** suggested that the dashboard might include more references to individual deaths to provide illustrative example. The **Chair** stated he would need to think further on how to do this justice as well as all other information. In closing, he thanked everyone for coming to the meeting and to the secretariat team for organising. He also thanked everyone who attended online.

Action 14: Secretariat to consider amending agenda to increase time for discussion and to include information on individual deaths within the data dashboard.

Date of next meeting: Spring 2025 tbc