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

Ministerial Board on Deaths in Custody minutes, 15 July 2025

Attendees

Dame Diana Johnson DBE MP (Chair), Minister for Policing, Fire and Crime Prevention, Home Office (HO)
Lord Timpson OBE (JT), Minister of State for Prisons, Probation and Reducing Reoffending, Ministry of Justice (MoJ)
Tabitha Jay (TJ), Director of Mental Health, Disabilities, and Women's Health, Department of Health and Social Care (DHSC) (for Baroness Merron)

Samantha Newsham (SN), Deputy Head of Police Powers Unit, HO
Frances Hardy (FH), Deputy Director, Detention Services, Immigration Enforcement, HO
Sam Johnston Hawke (SJH), Head of the MBDC Secretariat, MoJ
Steven Malcolm (SM), Mental Health and Offender Health, DHSC
Sarah Coccia (SC), Chief Operating Officer of Prisons, HM Prison and Probation Service (HMPPS) *(for Michelle Jarman Howe)*
Terence Davies (TD), Deputy Director, Death Management, Inquiries and Coroners, MoJ
Sarah Warmington (SW), Deputy Director of Specialised Mental Health, Learning Disability and Autism, NHS England
Angelique Whitfield (AW), Deputy Director Integrated adult pathways and SAAS Health and Justice, NHSE *(for Kate Davies)*
Her Honour Justice Alexia Durran KC (AD), Chief Coroner
Assistant Chief Constable Ivan Balhatchet (IB), Police Lead (Custody), National Police Chiefs' Council (NPCC)
Martin Lomas (ML), Deputy Chief Inspector**,** HM Inspectorate of Prisons (HMIP) (*for Charlie Taylor)*
Kate Green (KG), Joint Lead for Mental Health and Custody, Association of Police and Crime Commissioners (APCC)
Adrian Usher (AU), Prisons and Probation Ombudsman (PPO)
Nicola Marfleet (NM), Director of Investigations, Independent Office for Police Conduct (IOPC)
Jenny Wilkes (JW), Interim Director of Mental Health, Care Quality Commission (CQC)
Mitch Long (MiL), Policy Manager, Independent Monitoring Boards (IMBs) *(for Elisabeth Davies)*
Sherry Ralph (SR), Chief Executive, Independent Custody Visitors Association (ICVA)
Pia Sinha (PS), Chief Executive Officer, Prison Reform Trust (PRT)
Deborah Coles (DC), Executive Director, INQUEST
Karen Lancaster (KL), Portfolio Director for PEEL Inspection Programme, 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
Andrew Harris (AH), IAPDC
Kate Eves (KE), IAPDC
Andrew Neilson (AN), Director of Campaigns, Howard League for Penal Reform *(for Andrea Coomber)*
Lis Skeet (LS), Executive Director for Operations, Samaritans
Martin Jones CBE (MJ), Chief Inspector, HM Inspectorate of Probation
Keith Fraser (KF), Chair, Youth Justice Board

Item 1: Welcome, apologies, actions and minutes

1.1 The **Chair** thanked everyone for attending the meeting. She noted apologies from Baroness Merron and that TJ would be standing in for her. She welcomed new members Lis Skeet from the Samaritans; Nicola Marfleet, IOPC; Karen Lancaster, HMI Constabulary and Fire & Rescue Services; and David Whalley, Chair of the Lay Observers.

1.2 Minutes from the last meeting in November 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 and 2025 workplan

2.1 **SJH** gave an overview of the Secretariat's consultation in 2024 of Board members to identify their key priorities, the results of which were then discussed at the last Board meeting in November 2024. He reminded members that the three priorities were: a) improving mental health provision; b) identification and management of risk factors and information sharing; and c) data, investigations, and learning. Members' feedback on those priorities have helped to form the overarching themes of the new Ministerial Board workplan which has since been populated with workstreams across the Board's departments and agencies. The aim of this discussion was to get members' thoughts, comments and concerns on the draft workplan, particularly if there were areas where the Government and partner agencies could go further.

2.2 **LS** noted that on item 4 on combatting isolation, there was currently only one year of funding agreed for prison Listeners. Samaritans were working with HMPPS on seeking a multi-year funding agreement. She also noted the work on postvention support in prisons and stated she was aware of operational issues and capacity problems. **DC** stated that it was still not known what was happening with the Mental Health Bill and the new NHS 10 Year Plan, which may impact the workplan. She asked whether there had been any consideration of the 28-day statutory transfer of prisoners considering the capacity issues in the mental health estate. **JT** advised that legislation was going through and that a robust plan needed to be in place to ensure the timeliness of transfers. **SW** stated that NHSE are working with health and justice colleagues on a rapid review of secure mental health and psychiatric intensive care units (PICUs) to understand the challenges and ensure facilities were in place to hold prisoners and support moves back to prison and into the community. An advisory group was working on this and will feedback to ministers on progress in due course. **MJ** provided an update on item 3, noting that the Chief Inspector of Probation will be introducing inspections of all approved premises which they expect to be complete in three-to-four years.

2.3 **The Chair** asked that any further comments on the workplan be fed back directly to the Secretariat.

Item 3: Learning lessons database update

3.1 **JM** explained that new reforms to police accountabilities were announced last year, including setting up a database to ensure lessons are learnt from deaths and serious injuries and that these are fed into professional practice. She will update Board members at

a later date on the findings. The College of Policing (CoP) have adopted a systems-based approach using the Swiss Cheese model developed by James Reason in 1997. By studying organisational accidents, he observed that they almost always occur as a combination of causes, both errors at the 'sharp end', combining with mistakes and failures in the upper echelons of the organisation, coming together to create an opportunity or accident trajectory which can penetrate the system's defences. Typically, a serious incident usually starts with a human error or violation on the frontline, a poor decision, or an unsafe act committed by someone at the 'sharp end' of the system, termed as an 'active failure'. In the past, investigations and lessons learnt might have started and ended with these 'sharp end' failures, where blaming the individual may have suited the investigator and the organisation. However, unsafe acts now tend to be seen as consequences not causes.

3.2 CoP are developing a database and coding framework that will take investigation reports and analyse and detect patterns. They are starting to trial the use of AI for coding for longer reports, which is looking promising (95% accuracy to date). Once the database is complete, they will carry out a dummy analysis to demonstrate what the system can do. A prototype database will be produced by the end of September 2025 with pathways to practice recommendations for which they have a small pot of money.

3.3 **DC** asked if they would be using inquest or PFD reports. **JM** stated that PFDs have already been used and that the intention is to broaden the scope of reports being fed in to the system. **AW** stated that NHSE have built a similar database and that there may be some learning to take from that; the Secretariat to follow up. **JM** will provide an update for the autumn Ministerial Board

3.4 **SR** noted that the National Preventative Mechanism is developing a public database on recommendations arising out of deaths in all state custody and that she will be happy to provide any further information as required.

Action 1: Secretariat to contact NHSE about their learning lessons database to identify any learning which may be shared with the College of Policing.
Action 2: College of Policing to provide a written update on the Learning Lessons Database for the autumn MBDC.

Item 4: Independent Advisory Panel on Deaths in Custody update

4.1 **LE** stated that the last few months have been busy for the Panel, with two new Panel members joining; Kate Eves and Andrew Harris, present at the meeting. She provided a brief update on Panel work with the NPCC on preventing post police custody deaths and introduced the Panel's report on Investigating Deaths Under the Mental Health Act.

4.2 **JH** noted that deaths in MHA detention are largely investigated by the Trust responsible which is out of step with other custody settings. While there are gaps in the data, the number of deaths under the MHA is high. The Panel's report highlights the need to ensure parity and cross custody data analysis and leans towards utilising existing expertise as the most efficient way to fill the gap. He summarised that the purpose of the report is to ensure parity with other detention settings, assist in meeting Article 2 obligations, develop and share thematic learning and improve data collection. There will be further scoping activities to conclude the detail.

4.3 **IB** noted the important work on preventing post custody suicides which will help to identify cohorts at increased risk to ensure proper duty of care for people leaving custody suite. **SB** explained that NPCC have written to all Chief Constables in forces where there were deaths in custody in the last five years and have had good responses. Initial observations are that a high proportion are unemployed individuals, alcohol dependency is higher than that for drugs, police bail is a high-risk factor, and the most prevalent bail condition is contact ban. They are looking into under-reporting of post custody suicides: a number of forces have responded with "unknown" about whether detainees are being given information leaflets and this will need to be explored.

4.4 **JT** stated that 50% of people in custody die in hospital. He asked for more information on those who were moved into secure mental health hospitals and was especially concerned about IPP prisoners. On premature deaths, he noted the rise in serious organised crime groups testing new drugs on vulnerable prisoners.

4.5 **TJ** thanked the Panel for their recommendation and passed on Baroness Merron's gratitude for taking the time to meet with her. She stated there are still too many deaths in MH detention. The timing of the Panel's report coincides with the NHS 10 Year Plan and the Dash Review which was helpful as the latter is attempting to streamline the safety landscape and provides an opportunity to consider how they could deliver the principles of the report without complicating the space. She noted that there will be further discussions on this. **SW** said she would welcome the opportunity to be part of those wider discussions, being mindful of all the processes already in place.

4.6 **KG** asked if NPCC are collating data on previous interactions of people with the Criminal Justice System and if they were looking at the earliest points to identify vulnerability before the period in custody. **SW** noted the need to choreograph the timeline of investigations as some natural cause deaths are from physical health conditions as well as mental health. **IB** stated that the data will resolve several issues but may raise more questions about individuals' paths prior to their current period in custody and may result in a much bigger piece of work.

4.7 **DC** welcomed the Panel's report. She noted that 10 years ago INQUEST presented a report to the Board on the lack of independent investigations of deaths in mental health settings and that it is on the agenda again. In the context to the Lampard Inquiry into deaths in Essex mental health services, INQUEST have given their evidence. It was also clear from families giving evidence that they have deep-rooted concerns about the way in which investigations are conducted, that attempts have been made to reform the investigation system yet the issue of the lack of independence is raised time and again. She was in favour of an independent body taking on the role, that this could be a role for the PPO if they expanded their remit but that families may struggle with the PPO investigating. A value of having an independent body is the role it can bring to oversight and learning can bring when it's its main function. She recommended early publication and noted that she had flagged the report to the Lampard Inquiry who had shown interest.

4.8 **JH** responded that the recommendations were likely to change in view of the Dash Review but that the principles would remain the same. The report had only been circulated to Board members, not more widely, and that there may be recommendations which would not be taken forward. **DC** stated that she was happy to discuss further. **AU** stated that the PPO fiercely guard their reputation of being independent. **KL** stated that HMICFRS would like to feed into this work.

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.

Prisons

5.2 **SC** noted that the most recent statistics show a 37% increase in total numbers of deaths but that rates have stayed largely the same. The increase in the figure is likely due to the high number of natural cause deaths as well as a steadily growing number of older prisoners. There has been an increase in the number of homicides compared with the previous year from one to seven; analysis suggests that these are individualised cases rather than links or trends, but they will continue to monitor. There are a high, though not unprecedented, number of 'awaiting further information' deaths. These are later recategorised but this takes time. The numbers of self-inflicted deaths remain unchanged.

5.3 On capacity, **SC** noted that they were today operating at 98.2% in the adult male estate. To manage the issue, HMPPS are building more prison places, reforming sentencing, have increased use of Home Detention Curfew and laid a fixed term recall Statutory Instrument which is estimated to create around 1,400 prison spaces from September. Operation Safeguard has been deactivated. **JT** welcomed the reduced capacity figures.

5.4 **AU** agreed that the aging prison population is leading to more natural deaths but the number of unclassified deaths, often drug-related, has doubled in the past year. **SC** stated that the prison Safety Team is looking into this. **AH** noted that lessons can also be learnt from natural deaths, many of which may be preventable as they may include drugs, disease or system failures. **DC** referenced an inquest of a restraint-related death of a young Black man who had ligatured and was then restrained by staff which was found to be inappropriate and disproportionate. It was the first restraint-related death in prison she was aware of. She will share details with **SC** and asked the Ministerial Board to consider this as an item for a future meeting. **AN** questioned whether the rise in overall total deaths was putting a strain on investigative resources. **AU** responded that he had moved internal resources around to accommodate. **SC** noted that the PPO's focus on fewer but more focused recommendations has helped organisational learning. **LS** asked about availability of data on attempted suicides; **SC** stated they publish and have extensive data on self-harm incidents, but do not distinguish 'suicide attempts' as a category.

Action 3: Deborah Coles to share information on restraint-related death in prison with Sarah Coccia.

Immigration detention

5.5 **FH** noted that that was one natural cause death in 12 months (in a transient population of around 20,000 people per year) in respect of which they have undertaken a Lessons Learned Review. The average length of detention is decreasing, 97% are held less than 6 months as of December 2024. Incidents of self-harm requiring medical treatment has remained stable. Self-harm incidents requiring hospitalisation remains low, with six such incidents in the most recent six-month period. They have undertaken a lot of learning from near misses which they are sharing across the estate. Much work is underway to remove ligatures and they are applying all learning to new Immigration Removal Centres. There has been a recent trend in ingestion of dangerous items (for example, batteries, drawing pins,

detergent) and are working with NHSE colleagues to see what learning can be drawn from this.

Police custody

5.6 **SN** explained that there have been some fluctuations over time, and the 2023/24 figure is higher than the average of 17 deaths in or following custody over the 11-year period since 2013/14. There was one apparent suicide in a custody suite, the first since 2016. There were 68 apparent suicides after custody, an increase of 14 from the previous 12 months, with half of the people reported to be intoxicated with drugs and/or alcohol at the time of their arrest. There were 60 'other' deaths following police contact.

5.7 Key areas of progress include a NPCC portfolio on a 'betterment' workstream which focusses on healthcare provision in custody to reduce deaths and post-custody suicides. NPCC are also looking to integrate a national risk assessment model and a pre-release risk assessment with mandatory referral systems to support groups for at-risk individuals. **SN** highlighted a study on suicidal behaviour which will be starting in September 2025 and will run until December 2029, with the aim to identify common factors in deaths in custody and implement early interventions.

5.8 **IB** noted that NPCC are taking forward work on the treatment of women and girls in custody and piloting a 12-hour PACE clock for children in custody. They are also ensuring bail conditions are appropriate, and issues are progressed quickly. **DC** asked whether there was any work on restraint related deaths and **LE** stated that the Panel have this on their workplan this year.

Detention under the MHA

5.9 **SM** stated that the overall number of deaths is similar to previous years with a slight increase. There were 242 deaths in MHA detention, with 165 deaths of these undetermined. There were 14 deaths within seven days of restraint although this was not necessarily a causal factor. Capacity in mental health services is extremely strained, creating ongoing issues.

5.10 **SM** noted that the Panel attended the recent Mortality Data Working Group. Some actions were agreed and DHSC will convene a workshop in the autumn to better understand the data landscape. The NHS 10 Year Plan was published recently which is improving access to care by moving more care to the community, from analogue to digital, and from sickness to prevention. The Government has accepted all the recommendations from the Dash Review, including a more strategic allocation of resources. The Mental Health Bill is awaiting confirmation of the date for Report stage; once the Bill passes, focus will be on the mental health code of practice. **SM** noted also that the Chief Medical Officer has been involved in a review of healthcare in prisons.

Item 6: AOB

6.1 There was no other business. The **Chair** advised that the next Board meeting will take place in Autumn 2025, date to be confirmed.

Date of next meeting: Autumn 2025 tbc