Ministerial Board on Deaths in Custody minutes, 12 November 2025

Attendees

Baroness Merron (Chair), Parliamentary Under Secretary of State for Patient Safety, Women's Health and Mental Health, Department of Health and Social Care
Lord Timpson OBE (LT), Minister of State for Prisons, Probation and Reducing Reoffending, MoJ
Lizzy Gummer (LG), Deputy Director Police Powers Unit, HO *(for Sarah Jones MP)*

Samantha Newsham (SN), Deputy Head of Police Powers Unit, HO
Frances Hardy (FH), Deputy Director, Detention Services, Immigration Enforcement, HO
Paul Norris (PN), Deputy Director, Prison Policy, MoJ
Caroline Allnutt (CA), Deputy Director, Mental Health and Offender Health, DHSC
Helen Ryder (HR), Director of Prison Operations, HMPPS *(for Michelle Jarman Howe)*
Sarah Warmington (SW), Deputy Director of Specialised Mental Health, Learning Disability and Autism, NHS England
Kate Davies (KD), Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England
Her Honour Justice Alexia Durran KC (AD), Chief Coroner
DCI Simon Barnes (SB), National Police Chiefs' Council (NPCC) *(for ACC Ivan Balhatchet)*
Martin Lomas (ML), Deputy Chief Inspector**,** HM Inspectorate of Prisons (HMIP) (*for Charlie Taylor)*
Deputy PCC Emma Daniell (ED), deputy national lead for Mental Health and Custody, Association of Police and Crime Commissioners (APCC) *(for Kate Green)*
Adrian Usher (AU), Prisons and Probation Ombudsman (PPO)
Jenny Wilkes (JW), Interim Director of Mental Health, Care Quality Commission (CQC)
Mitch Long (MiL), Policy Manager, Independent Monitoring Boards (IMBs) *(for Elisabeth Davies)*
Jenna Walop (JWa), Membership, Training and Engagement Manager, Independent Custody Visitors Association (ICVA) *(for Sherry Ralph)*
Pia Sinha (PS), Chief Executive Officer, Prison Reform Trust (PRT)
Deborah Coles (DC), Executive Director, INQUEST
Lauren Cockburn (LC), Deputy Director Peel Portfolio, 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 member
Andrew Harris (AH), IAPDC member
Kate Eves (KE), IAPDC member
Seena Fazel (SF), IAPDC member
Andrea Coomber (AC), Chief Executive, Howard League for Penal Reform
Martin Jones CBE (MJ), Chief Inspector, HM Inspectorate of Probation
Keith Fraser (KF), Chair, Youth Justice Board

Apologies

Sarah Jones MP, Minister for Policing and Crime, Home Office
Lis Skeet, Executive Director for Operations, Samaritans
Nicola Marfleet, Director of Investigations, Independent Office for Police Conduct

Item 1: Welcome, apologies, actions and minutes

1.1 The **Chair** thanked everyone for attending the meeting. She noted apologies from new Board co-chair, the Minister for Policing and Crime, Sarah Jones MP.

1.2 Minutes from the last meeting in July 2025 were approved and circulated with other papers. The **Chair** asked that any questions or comments about the minutes and actions be directed to the Secretariat. She advised members that the Board meeting would be shorter than usual to ensure attention on the most important updates. The agenda was focused on the work of the Independent Advisory Panel on Deaths in Custody and on custody updates, with additional time built in to allow time for discussion as previously requested by members.

Item 2: Deaths in custody dashboard and key custodial updates

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

Prisons

2.2 **HR** noted that the most recent statistics show a 30% increase in the total number of deaths, from 317 to 411. The increase in the published figure is largely the result of higher numbers of natural causes deaths, mostly of older prisoners, and it is too early to tell if this is anything more than a brief spike in the numbers. There has been a steadily growing population of older prisoners and analysis shows a link between age and deaths.

2.3 There was also an increase in the number of homicides, from five to six. Both figures are higher than those in most recent years, which have been three or fewer. These incidents are taken seriously, with HMPPS facilitating police investigations and prosecutions where perpetrators are identified and learning lessons from them. HMPPS are carefully monitoring the spike to ascertain whether it is a sustained increase; from current analysis it appears to be a short-term spike rather than a long-term trend, but the situation is being monitored closely.

2.4 There were 96 self-inflicted deaths in the latest year, an increase from 88 in the previous one. The rate has remained broadly stable – around 1.0 deaths per 1,000 prisoners since the 12 months to September 2018. Efforts continue to reduce this number.

Detention under the MHA

2.5 **CA** stated that the latest provisional data shows 314 deaths, of which 253 were detained and 61 were on a Community Treatment Order. The cause of 74 detained deaths is undetermined, 149 were from natural causes and 30 from unnatural causes.

2.6 In wider work, the Mortality Working Group has been looking at patient safety; its aim is to make better use of data and get better data sets which they hope to make available monthly. The Mental Health Bill is going through its final Parliamentary stages and the team are working on an implementation plan; full implementation will take 10 years but there are many aspects which can be enacted quickly. An important upcoming piece of work is to update the MHA Code of Practice, a statutory guidance for practitioners. They have also received £75m in funding to invest in addressing out of area placements to allow people to be moved closer to home. They have also published the new Planning Framework for the NHS and the Chief Medical Officer's report on health in prisons was published recently

which was a very detailed and comprehensive report and they will be working very closely with the MoJ and DHSC on the recommendations.

Police custody

2.7 **SN** explained that the number of deaths in or following police custody has decreased over the last full 12-month period, from 25 to 17. There were nine natural cause deaths and no homicides. There was one self-inflicted death (from a self-inflicted act during the detention process), which is down from three in the previous period. Five deaths involved restraint, with none of them currently classed as restraint related. Nine people were identified as having mental health concerns and 15 people were known to have a link to alcohol and/or drugs. **SN** referenced the case of Brian Ringrose who died in February 2021 which had led to the mandatory completion for police officers of an e-learning training package titled "Safer Restraint" and training scenarios emphasising the importance of communication with medical staff during an incident. She noted the good working relationship between the IAPDC and NPCC on the best practice guidance on preventing suicides following police custody which was published recently.

2.8 **SB** noted the NPCC's key areas of progress including looking to integrate a national risk assessment model and a pre-release risk assessment with a mandatory referral system to support groups for at-risk individuals. The next stage is to put all the research into a proposal paper for circulation with academics, partners and senior leaders in policing to obtain views and observations from stakeholders and include them in a final paper. On post-custody data, they are now receiving all information from police forces to identify commonality features for their analysis. They will be looking into bail stigmatising offences, which seems to be a particular correlating factor, what is known about the individual, and healthcare-related correlation. This work will be delivered in the early part of 2026.

Immigration detention

2.9 **FH** noted that that was one natural cause death in the last 12 months and a recent natural cause death after release. There were two recent inquests into deaths though neither resulted in a PFD report. They are focusing on reducing ligature points including through items such as anti-ligature shower furniture, and removal of TV brackets and radiator covers. They are opening a new Immigration Removal Centre within the next few months and are grateful to HMPPS for their support and sharing of lessons learned. There has been a recent trend in battery ingestion, and they are working with HMPPS and NHSE colleagues to address this to safeguard vulnerable persons.

Further questions

2.10 **KE** asked whether the new MHA guidance for practitioners will address interaction with families as this is an area where it is difficult to pin down lessons to be learned and good practice in trusts. **CA** stated that family involvement will be a key theme and agreed to feed in families work from the IAPDC. **LC** asked if it would it be possible to have an overview in the pack on the location (for instance, police force or region) of where the deaths and suicides in custody are taking place – SN agreed to raise this with the IOPC. This would support an understanding of the context behind them and possible trends. **CA** agreed to work with the Panel.

Action 1: IAPDC and DHSC to work together to include material on interaction with families in the new MHA guidance for practitioners.

Action 2: IOPC to include information in the MBDC dashboard on location of deaths and suicides in custody.

2.11 **DC** noted that there was a family behind every statistic. INQUEST was seeing many comments from coroners around serious systemic failings which showed a real accountability gap in terms of learning and impact of change. She referenced two deaths which the IAPDC may want to consider further, while noting that it was extraordinary that the MBDC meeting had been cut to one hour, given the scrutiny these issues need. The first death for consideration was that of Sundeep Ghuman, an Asian man killed by his racist cellmate and the conclusion in the inquest raised almost identical findings of that following the murder of Zahid Mubarak, whose family remembered his death at a conference last week. The second was the death of 22-year-old Alice Figueirido, while in care of North East London Foundation Trust (NELFT) MH services, who took her own life after repeated failings on behalf of the Trust and the Trust manager to safeguard her life.

2.12 **DC** stated that this was another case that raises fundamental questions about how these deaths are investigated. There was a long delay for the family getting justice, with the Trust resisting criticism and giving no apology despite receiving 27 PFD reports raising similar issues. She suggested a discussion was needed about what it means to learn and how to effect change on the ground as the same concerns are flagged time and again. **JT** noted that since there is ongoing litigation in the case of the death of Sundeep Ghuman he cannot speak about it. But he had attended the Zahid Mubarek family conference a couple of weeks ago, and stressed the importance of focussing on this issue and the need to continue reviewing policy and communicating well. He thanked DC for raising these issues. **CA** expressed her sadness at the case of Alice F, while noting that there have been reviews and investigations at Trust level with some significant improvements, for instance, to staffing ratios. The case is within the scope of the Lampard Inquiry which may provide some illumination.

2.13 **AC** stated that it is well known that the health of those in prison is poor, their life expectancy is lower by 20 years, and that the natural deaths increase may be attributed to the increasing age profile. However, she stated that just because deaths are natural does not mean they are not preventable, and asked what work is being doing on this in light of the CMO report. **HR** stated that HMPPS are aware that there is work to do locally and nationally to improve health outcomes, but that there are investigations to determine whether older prisoners get comparable care in custody. They will be looking at the CMO report with interest and working with health partners on how to progress nationally.

2.14 **MJ** suggested that Approved Premises (AP) should be on a future agenda. HMI Probation have started an AP inspection programme and have carried out six inspections to date. He noted that one thing they look at is safety of residents and public protection. Although outcomes have been generally positive, they did raise an organisational alert on 26 September at one premises about staffing deficit impact on safety of residents and understanding of suicide risk and controls around medication. **MJ** also suggested that more AP data be included within the custody updates in future.

Action 3: Secretariat to include Approved Premises data in future custody updates and to consider APs as an agenda item at a future Board.

2.15 **PS** proposed that when the Sentencing Bill is enacted it would be useful to see metrics for deaths following release. The Board should start measuring these now so that there is a comparator and accountability in terms of impact, especially as probation becomes increasingly stretched and there may be a de-prioritisation of cases. **KD** noted continued concerns from healthcare teams on enablement of care and movement of prisoners as patients, including older persons, and poor community screening around

cancer of persons arriving in prisons. **JT** suggested consideration of a discussion on what can be done to encourage more compassionate leave from prison due to health grounds at a future meeting. **PN** noted that there is already a commitment to review the older prisoners' strategy and this is due to start this Autumn.

Action 4: Secretariat to engage HMPPS compassionate release team to take forward Panel and MBDC interest in this area.

Item 3: Independent Advisory Panel on Deaths in Custody update

3.1 **LE** stated that the last few months have been a busy and productive time for the Panel, with a comprehensive workplan and focus on compassionate release and Approved Premises as areas needing further development. Panel members Jake Hard and Seena Fazel contributed chapters to the recent Chief Medical Officer report. The Panel have also published several reports following extensive work:

- Guidance on preventing suicides following police custody, developed in collaboration with NPCC and CoP and embedded in all APPs for police forces.
- Ligature deaths in prisons, also the subject of an MBDC policy forum which members attended and a thematic digest was circulated with the papers.
- Prison overcrowding and deaths, a timely report which should be helpful to Ministers and others and **LE** was keen to discuss further with Ministers.
- Investigating deaths under the MHA, another significant and timely report, linking together comments already discussed such as families and the investigation process when somebody dies in MHA detention. **LE** expressed her hope that progress can be made towards achieving parity across detention settings.

3.2 **SF** explained that the Panel had looked at 15 years of data on ligature related deaths in prison equating to 1885 deaths, around 70-80 deaths per year. They looked at methods, ligature points, and a range of other prison related variables that might inform prevention of such deaths going forward. HMPPS need to consider that a national and co-ordinated approach to removing ligatures in cells was needed. It was not enough to simply have a safer cell policy and delegating decisions to individual governors did not address needs nationally as there may be trends over a period of time that individual governors will not be aware of. The Panel looked also at international literature for lessons about prison architecture from Switzerland and Australia. The Panel stated that risk assessment monitoring must continue after an ACCT is closed – it should not just end there and can, in the Panel's view, be improved.

3.3 On the prison capacity report, **SF** described how the Panel looked at likely projections of prison numbers over the next 5 years with a predictive model to understand the effect on mortality. The main finding was that there will be a disproportionate effect on deaths, particularly self-inflicted deaths in Category B prisons which are exacerbated by overcrowding. They recommend that consideration be given to targeting, if there are resource restraints, to prevention measures in Category B prisons in particular and also those that are most overcrowded. The final recommendation, which also underscores many other IAPDC reports, is around the gap in evidence and data availability. The report also recommended that more work is needed to understand links between increasing numbers of prisoners and increasing assault rates to ascertain if a relationship with deaths exists, and to drill down into the types of Category B prisons to help target prevention efforts more precisely.

3.4 **JH** noted that an early version of the Panel's report on deaths in mental health settings was shared at the last MBDC meeting and a final copy has now been published. Following the Dash review and the NHS 10-year plan, the recommendation was amended to say that DHSC should sponsor the establishment of an independent mechanism to investigate deaths using existing resources; this could be part of one distinct body or through collaborative work between different bodies. The new mechanism would need to work with relevant health regulatory bodies including the CQC. Clinical leadership needs to be embedded within independent investigative mechanism to oversee and quality assure clinical advice, and all deaths should be investigated, both natural and non-natural.

3.5 The **Chair** thanked the Panel for their work. **JT** advised that he attended a "Dragons Den" event for new technology, pitched to various businesses including around ligature prevention and real-time sensors to indicate if someone is gearing up to ligature. He will update further on the trials and plans.

Action 5: Secretariat to follow up on trials for ligature prevention sensors ahead of the next Board meeting.

3.6 SN recorded her thanks, on behalf of the Policing Minister and Deputy Director Lizzy Gummer who was standing in for the Minister, for the publication of the post-custody suicide guidance and the best practice from the wide range of partners contained within it. **DC** also congratulated the IAPDC on their report on MHA deaths and for reiterating the anomaly that exists in the way those deaths are investigated in comparison with other detention settings. She described how these issues arose frequently in her work and asked when there would be a response from government. She noted that INQUEST and families had talked at length of the importance of independent scrutiny of these deaths at the Lampard Inquiry. **CA** apologised for not yet assigning a timescale but was grateful for the report and its thoughtful and pragmatic approach to a difficult issue and noted that they are speaking to a number of bodies to discuss next steps. They are thinking about it in the context of the new framework of the NHS 10-year plan, at the overall landscape of patient safety, not just mental health, and how it aligns with that.

Action 6: DHSC to update the IAPDC after the meeting regarding the Government's response to the IAPDC report on Mental Health Act investigations.

3.7 DC asked for an update on when the outstanding sections of the Use of Force and Mental Health Units Act 2018 will be implemented. **CA** stated that she hoped it would as early as possible next year; it is a key part of implementation of their reformed approach to legislation. The team taking forward secondary legislation on Mental Health Bill will also be taking forward remaining commencement regulations on the Use of Force Act. **AC** asked if there would be a formal response to the Panel's capacity report. **HR** will ascertain and feed back to the Board.

Action 7: HMPPS to provide update on its response to IAPDC report on capacity modelling.

3.8 KD noted that the Panel's two reports also help to focus on reduction of deaths as the Ministerial Board's key priority, and one action is to review on how the £75m capital can help the CJS pathway and not continue to use custody as a place of safety.

3.9 The **Chair** thanked the IAPDC for their reports which were very well received and valuable. She noted her thanks to LE whose term of office as Chair of the IAPDC comes to an end in February 2026 and wished her well on behalf of the Board membership.

Item 4: AOB

4.1 **KF** stated that he had met with LE and the Panel recently to discuss children and self-harm in the youth custody estate and the increased number of girls with additional vulnerability. Though it is not in the current Board workplan he hoped in the future the Board could keep an appropriate oversight on children in the secure estate. He welcomed government's additional attention to girls and hoped that the people and knowledge at the Board would do what they could to prevent the self-harm and violence increasing among girls.

Action 8: Secretariat to consider issues in the youth custodial estate as part of future Board meetings and work.

4.2 **DC** noted that she hoped that one-hour meetings would not be the normal practice moving forward. **JT** reiterated the really important work of the Board. He referenced the points from KF and noted that girls make up less than 10% of the custodial population but are responsible for over half of all self-harm cases.

4.3 The **Chair** advised that the next Board meeting will be in Spring next year and the date will be issued in due course.