Independent Advisory Panel
Mid-term report 2016-18

May 2018

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Foreword from the Chair

It is 18 months since I took over as chair of the Independent Advisory Panel on Deaths in Custody. This offers a good opportunity to take stock of what the IAP has achieved in that time, and where it can help further to provide independent advice on how to keep people safe in custody. Since September 2016, I have met a great many people held in, responsible for, and with an informed interest in, custody including prisoners, family members and prison staff, patients and clinical staff, immigration detainees and staff and those in police custody suites, Ministers, operational leads, regulatory and investigatory bodies and wider stakeholders. What has been clear – and encouraging, though not surprising – is that there is huge willingness and commitment to prevent deaths in custody. I am pleased that the IAP has managed to work collaboratively with so many groups and individuals and look forward to building on and extending this over the next 18 months.

Our ambit is wide - aiming to reduce both natural and self-inflicted deaths of people detained by the state in prisons, police custody, hospitals and immigration centres. The Panel has been particularly concerned about the sharp increase in self-inflicted deaths in the prison estate since 2014. In response to these deaths, the IAP produced two substantial reports during this period: *Preventing the Deaths of Women in Prison* and *Keeping Safe; Preventing Suicide and Self-Harm in Custody*. I am very grateful to the many prisoners, health and justice professionals and other stakeholders who contributed to our wide-scale consultation exercises. Both these reports reflect the IAP's new guiding principle to consult people who are, or have been, held in custody and draw on their views and experience when recommending changes. Findings and recommendations have been presented to Ministers and the IAP is working with officials and governors to ensure that the learning is applied and remains high on their agenda.

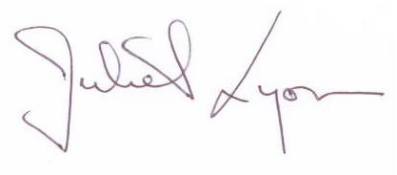
Every death in custody is a tragedy – for the individual, family and friends, staff and all of us as a society. Notwithstanding the known vulnerability of many people in custody, the starting point has to be that self-inflicted deaths are avoidable not inevitable. We acknowledge the recent marked reduction in self-inflicted deaths, from 122 men in 2016 to 70 in 2017, from twelve women in 2016 to two in 2017 and continue to work closely with colleagues in the Ministry of Justice and HM Prison and Probation Service in their determined efforts to prevent such tragic deaths.

Elsewhere, the IAP is working with the Ministerial Board on Deaths in Custody to take forward recommendations from Dame Elish Angiolini's review of Deaths and Serious Incidents in Police Custody. The IAP is exploring administrative measures to increase accountability, meet human rights obligations and ensure that those making major decisions consider, fully and consistently, their impact on the safety of people in custody.

My time as chair of the IAP has coincided so far with a significant amount of change. The high turnover among Ministers has complicated matters – the IAP is now working with the fourth Secretary of State for Justice since I was appointed and there have been two Ministers in each of our sponsoring departments successively in charge of prisons, policing and public health. Lead sponsor officials have changed three times in 18 months in each of the departments. However, some change has

been welcome – the IAP moved from HMPPS to the Ministry of Justice in 2017 with Ministerial approval of our terms of reference, strengthening our position as an independent non-departmental public body. Additional time has been allocated to panel members to increase the IAP's reach and effectiveness. An agreement has been reached with Ministers about the scope for the Board to become more pro-active.

The IAP will shortly change again, as new members join following a protracted public appointments recruitment process. This means that the IAP will soon say farewell to the current members who have contributed so much, not least to the Harris review, during their time on the Panel. I am grateful for the work they have done and for their support over the last eighteen months, largely on extended tenure. Building on the Panel's work to date, I look forward with new colleagues to widening our focus and setting priorities for what we plan to achieve by 2020. Our overarching aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.



Juliet Lyon CBE
Chair of the Independent Advisory Panel on Deaths in Custody

Independent Advisory Panel on Deaths in Custody – an introduction

1. In its current form, the Ministerial Council on Deaths in Custody formally commenced operation in April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and the Home Office. The Council consists of three tiers:

    - Ministerial Board on Deaths in Custody
    - Independent Advisory Panel (IAP)
    - Practitioner and Stakeholder Group

2. The IAP forms the second tier of the Ministerial Council. The remit of the Council covers deaths which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

3. The role of the IAP, an advisory non-departmental public body, is to provide independent advice and expertise to the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

4. Juliet Lyon CBE was appointed Chair of the IAP in September 2016. Further information on the IAP can be found on its website: http://iapdeathsincustody.independent.gov.uk/

IAP Terms of reference

5. The Independent Advisory Panel (IAP) on Deaths in Custody will:

    - Act as the primary source of independent advice to ministers and service leaders (both through the Ministerial Board and where appropriate directly) on measures to reduce the number and rate of deaths in custody
    - Consult and engage with Ministers and the Ministerial Board to identify the key areas of advice and research to enable the operational services to reduce the number and rate of deaths in custody.
    - Consult and engage with relevant stakeholders in order to collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them
    - Commission relevant research
    - Carry out thematic enquiries into areas of concern, in co-operation as appropriate with the relevant oversight and investigative bodies
    - Issue formal guidance (and where appropriate set common standards) on best practice for reducing deaths in custody, both on its own authority and where appropriate under the authority of the Ministerial Board

- Monitor compliance with such guidance and standards
- Where appropriate, make recommendations to ministers for changes in policy or operational practice, which would help to reduce the incidence of death in custody.

Administrative changes made to strengthen the IAP

6. In Autumn 2015, Kate Lampard, interim chair of the IAP, was asked to review the purpose, operation and performance of the IAP following Lord Harris as chair, including its relationship with the Ministerial Board as part of a Cabinet Office process for reviewing the function of Non-Departmental Public Bodies. Kate's review was completed and delivered to the Secretary of State in April 2016.

7. The review made a number of recommendations, principally that the IAP should be strengthened and resourced to complete more work which has greater alignment with the priorities of the departments and custodial services concerned. She also recommended that the advisory relationship of the IAP and the Ministerial Board be strengthened and further aligned. As a result of the review, Ministers agreed a number of changes to improve the functioning and governance of the IAP:

- Resources: Ministers approved a change to the number of days payable to Panel members which significantly increased the amount of work they could undertake.

- Governance: the IAP's administrative location was moved from HM Prison and Probation Service to the Ministry of Justice in 2017. This aligned the IAP's governance arrangements with each of the sponsoring departments made them more consistent.

- Terms of Reference: Ministers have reviewed and reconfirmed the terms of reference (outlined above) which set out the primary role for the IAP is advising Ministers and the Ministerial Board on the best ways to reduce deaths in custody.

- Consultation with those in custody: The IAP has adopted the guiding principle that, when developing reports or recommendations, it will engage in a process of direct consultation with people detained by the State. The IAP has decided this for two reasons. Firstly, people in custody are experts by experience. They see and hear and know things about life behind bars that others don't. Secondly it is becoming increasingly evident across a range of public policy areas that policy design works best when it is informed by those who use the services or live in them, as with prisons.

- Panel Member Recruitment: A public appointments process for new panel members started last year and is now due to complete spring 2018.

Update on IAP work over the last 18 months

8. The IAP's advisory role across three departments gives it a wide remit, which has allowed the Panel to work on several different activities over the last 18 months. The section below outlines some of the pieces of work that have been delivered.

Ministerial Board on Death in Custody meetings

9. The chair of the IAP is a member of the Ministerial Board and attended all three meetings of the Board during this period (November 2016, November 2017 and February 2018). Full minutes of the Board meetings can be found on the IAP's website.

Meetings of the Independent Advisory Panel on Deaths in Custody

10. The IAP held eight formal panel meetings between September 2016 and March 2018, as well as a number of smaller meetings concerning specific workstreams. During this time the panel discussed their priorities and objectives, the re-shaping of the panel following Kate Lampard's review and how they could help to drive forward the recommendations of Dame Elish's review of *Deaths and Serious Incidents in Police Custody*. These meetings also considered and moved forward specific IAP outputs during this time such as the statistics report, Keeping Safe project and report on the deaths of women.

Preventing the deaths of women in custody – December 2016 onwards

11. Following the self-inflicted deaths of 12 women (and 20 in total) in prison in 2016 - the highest recorded number since 2004 - the Panel conducted a rapid expert information gathering exercise in order to advise Ministers and operational leaders and reduce the risk of further tragic deaths.

12. The IAP received approximately 50 detailed, well-evidenced responses from members of the Ministerial Board on Deaths in Custody, the Advisory Board on Female Offenders (ABFO) and IAP stakeholders with their views on how best to prevent suicide and self-harm and keep women safe. At the same time – in line with the IAP's decision to consult those in custody - the IAP sought the views of women in prison, particularly those acting as Samaritan Listeners, insiders and responsible peer mentors. In total, the IAP met and, heard from, over 60 women in custody.

13. There was a high degree of agreement across the information received by the IAP. The points raised by both external experts and the women who the IAP consulted in prisons can be summarised as:

- Insufficient attention is paid to preventative work and effective community sentences which would avoid separation from family, the losses sustained by imprisonment and the uphill battle on release to find somewhere safe to

live and a means of earning a living – all of which increase the risk of suicide and self-harm.

- Concerns were raised about insufficient information for the courts, an absence of pre-sentence reports or mental health assessments and a tendency to resort to use of prison as a place of safety.
- There are examples of good practice before, during and after custody – however, these providers are struggling with resource pressures and the lack of a gender-specific approach to safeguarding women.
- Women prisoners are different to men– in terms of vulnerability, offences, personal histories and caring responsibilities – and should be treated as such.
- The reduction in staff numbers and loss of experienced staff has had a negative impact on the ability of prison governors and staff to build and maintain consistent, trusting relationships with the women in their custody.
- Mental healthcare and treatment for addictions are overly variable and require greater consistency in design and application to meet acceptable standards
- The work of Samaritan Listeners and Insiders is inspiring and indicates the potential for self-help and peer support.
- Transfer of information between agencies and between prisons can and must be improved in order to keep women safe and those who work with them fully informed.
- Family contact is hugely significant factor in keeping women safe in custody and on release – yet prison location, technology and visiting arrangements make this harder for women than men.
- Too many women are released with insufficient support – particularly in fundamental areas such as safe housing – leading to a quick return to addiction, crime and custody: the revolving door.

14. The IAP chair presented the paper on the date of publication, 28 March 2017, for discussion at the Advisory Board on Female Offenders, chaired by Justice Minister Dr Phillip Lee MP and discussed the report's findings and recommendations on BBC Woman's Hour.

15. A team in HMPPS is taking forward the recommendations of the report in conjunction with recommendations made by the Prisons and Probation Ombudsman in his thematic review. The IAP keeps a watching brief and is pleased to report that a number of recommendations have now been implemented across the women's estate ranging from improvements to first night arrangements and transfers to strengthening family contact and improving access to counselling and mental health care.

16. The IAP continues to engage with the judiciary, Ministers and other departments with regard to preventing the deaths of women in prison.

Keeping Safe - Preventing Suicide and Self-Harm in Custody – January 2017 onwards

17. Early in 2017, the IAP undertook a collaboration with Inside Time, Prison Radio and the Samaritans to reach out and listen to those in custody and seek their ideas for keeping people safe. This work was designed to present informed ideas to Ministers and officials, and to encourage prisoners that their views count and would reach those with the power to change things for the better.

18. Articles were placed in Inside Time on a regular basis, and a monthly 'Keeping Safe' page established, describing the project and how people could get involved, accompanied by an article or advert from the Samaritans explaining how to access immediate emotional support. At the same time, interviews were given and a phone consultation opened by the Prison Radio Association. The specific questions asked were:

- What do you think are the best ways to prevent self-harm in prison and respond to people's needs?
- What do you think are the best ways to prevent suicide in prison and keep people safe?
- What do you think can be done outside prison in the community that would help reduce the risk of self-harm or suicide - either before imprisonment or on release?

19. The IAP arranged for a Freepost address to be established, removing the disincentive of the cost of sending in letters from people in prison who might otherwise get in touch. Furthermore, it was subsequently agreed with HMPPS that such letters could be written under the 'confidential access' arrangement, meaning that the letters would not be opened before they reached the IAP. Many prisoners were concerned about the confidentiality of what they were writing, and we are grateful to HMPPS for appreciating this concern and putting in place a system to facilitate contact.

20. The reaction to the IAP's call for ideas and solutions was robust. The IAP received over 100 detailed letters and 50 transcribed telephone calls from prisoners across 60 prisons that demonstrated the determination to prevent needless deaths felt by those witnessing – and sometimes engaging in – self-injury and suicide attempts. We are grateful to Kathy Biggar, founder of the Samaritan Listeners, who worked with the IAP chair to reply to all the letters.

21. We received a notably consistent set of thoughts on both the problems and solutions required. A four-page supplement summarising the initial letters and telephone messages was published in the September issue of Inside Time and launched on the Radio 4 Today Programme and in the Huffington Post. The supplement was circulated to all prisons, the Ministerial Board, prison governors and safer custody leads.

22. The full Keeping Safe report was published in mid-December 2017 and includes reference to recent research, reports and recommendations made by, amongst

others, the Joint Committee on Human Rights, the National Audit Office (NAO), HM Chief Inspector of Prisons, the Prisons and Probation Ombudsman (PPO) and the Chief Coroner.

23. The solutions offered by prisoners can be summarised as:

- Staff with time and professionalism to support and encourage prisoners
- Meeting mental health need and treatment/maintenance for addictions
- Tackling debt, drugs, violence and intimidation in prisons
- Greater time out of cell and more meaningful activities such as work, release on temporary license (ROTL), exercise and education and an increase in contact with family
- And coming to grips with, amongst others, the enduring impact of the abolished IPP sentence; an incentives scheme (IEP) that has become unduly punitive; an assessment and care system (ACCT) that in some instances has been reduced to a box-ticking exercise; and overuse of recalls to custody for administrative reasons.

24. The IAP is pleased with the positive response the Keeping Safe report received from Ministers, operational leads and colleagues on the Ministerial Board. Going forward, the IAP will monitor and continue to discuss with Ministers and officials the ways the solutions offered by prisoners are being implemented.

IAP's annual statistical report

25. The IAP published its statistical report for 2015 in January 2017 with the assistance of Professor Graham Towl and Durham University. The Panel then discussed whether, in the current resource constrained environment, completing the usual annual statistical report would represent good value for money. The Panel assessed the likely cost of the work, the use of the data and availability of the statistics elsewhere – for instance, the National Preventative Mechanism now publishes information about where and how many people are detained including those in prisons, immigration centres, secure settings for children and young adults and psychiatric hospitals. The Panel agreed to remove this from its current workplan, and keep it under review.

IAP written and oral evidence submissions

26. The IAP have given evidence to several reviews and enquiries during this period including the following:

- Meetings and a submission to the Dame Elish Angiolini review on deaths and serious incidents in custody.
- Meetings and a submission to Lord Farmer on his review of family contact with prisoners.
- Meetings and a submission to David Lammy MP on his review of race and over-representation in the Criminal Justice System
- Written and oral submissions to the Joint Committee on Human Rights
- Discussions with Cabinet Office on their Review of Expert Advice

- Written and oral submission, with Dr Dinesh Maganty, to NICE guidelines on Preventing suicide in community and custodial settings

The IAP's response to Dame Elish Angiolini review of *Deaths and Serious Incidents in Police Custody*

27. In 2016, the Rt. Hon Theresa May MP commissioned Dame Elish Angiolini DBE QC to produce a report on Deaths and Serious Incidents in Police Custody. This report, and the Government response to it, was published on 30 October 2017[1] The Government response stated that the Home Secretary had asked the Ministerial Board on Deaths in Custody, with significant input from the IAP, to take forward further work in these areas: healthcare in police custody, inquests and support for families and increased accountability. Following discussions at the Ministerial Board on 1 November 2017, Ministers agreed a work programme for the Board which covered:

    - Healthcare in police custody - *Reduce the risk of a death in police custody occurring*
    - Support for families - If a death in custody occurs, ensure better support for families
    - Inquests and Legal Aid - If a death in custody occurs, ensure families are supported through the inquest process
    - Accountability - Ensure organisations are held to account
    - Investigations - Ensure investigations and inquests are timely and effective
    - Levers to improve performance - Ensure lessons are learnt and improve accountability

28. The following pieces of work undertaken by the IAP sit within the themes outlined above, developed in response to Dame Elish's review.

IAP's work to embed learning and avoid repeat recommendations

> *"Recommendations from past reports have not always been followed up in a coherent or joined-up way. There is no single national body that can monitor progress and maintain the momentum and pressure for institutional change. As a result, progress tends to be piecemeal. The same failings, and the same issues, appear to manifest themselves time and again."* Dame Elish Angiolini

29. The IAP has been exercised by this issue for some time and in 2015, under Lord Harris' chairmanship, undertook some initial scoping work. The IAP has re-engaged with the problem of repeat recommendations and over the last few months has been consulting on how best to embed recommendations across, and within, all custodial sectors. In October 2017, Juliet Lyon, IAP chair, discussed potential solutions with the former Prisons Minister, Sam Gyimah MP,

[1] https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody

who encouraged the IAP to undertake a *"piece of work that focuses on drawing out the 'top ten lessons' and more specifically to understand better how these can be embedded in practice across the estate."* The synergies between this work and concerns raised by Dame Elish have led this workstream to be included in the Ministerial Board's work programme.

30. The aim of this piece of work is to reduce deaths in custody by:

- collating the main, or 'top ten', recommendations made by scrutiny bodies that, if successfully implemented, would have the most impact in preventing such deaths,
- identifying effective methods of embedding these recommendations in policy and practice,
- advising Ministers, officials and operational leads accordingly, and
- monitoring implementation and outcomes.

31. In January 2018, the IAP chair and panel member, Stephen Cragg QC, convened a meeting with regulatory and investigative bodies to determine which recommendations to select. Following consultation, a paper is to be presented to the Ministerial Board in June setting out recommendations that will make the most impact and methods to ensure implementation and embed learning.

Alternatives to restraint

32. The police's use of restraint techniques has been reviewed and considered by a number of bodies. In 2017, a Memorandum of Understanding developed by a group independently chaired by Lord Carlile of Berriew CBE QC sets a clear national position about when the police can be asked to attend mental health settings, for what reasons and what can be expected of them when they do attend.

33. The Government, and the Ministerial Board on Deaths in Custody, in their response to Dame Elish's report have been clear that further focus needs to be given to examining potential alternatives to the use of restraint by police officers when faced with situations in the community. The IAP agreed to take this research forward given the Panel's previous work on the use of restraint in custodial settings[2], and present the potential alternatives with the help of Dr Meng Aw-Yong (without necessarily suggesting that any of the alternatives considered should be adopted).

34. The IAP's role with this report was to produce alternative options to physical restraint for consideration by the Ministerial Board on Deaths in Custody. The IAP's intention is to encourage debate and discussion of the possible options, rather than actively promote any of them.

[2] http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/use-of-restraint/

35. The report was submitted to the February 2018 Ministerial Board, and is currently being considered further by members of the Board working on this workstream.

Looking forward

36. This mid-term report covers the first half of the chair's three-year term. A good deal has been achieved over the first 18 months and the IAP is committed to continuing to deliver over the second year and a half and beyond. The sections below outline some of the areas where attention will be directed during this time.

Building, and rebuilding, networks

37. The past 18 months have involved the IAP in building and strengthening relationships with the many stakeholders involved in improving safety in custody. Some of these – such as those in the female prison estate and the scrutiny bodies – have already resulted in tangible benefits for those in custody. The IAP looks forward to building on the many strong relationships over the next 18 months.

38. There are also a wide range of relationships that can be further developed. The IAP recognises that the judiciary plays an important role in the wider criminal justice system, determining, in large part, which people are placed in custody and who should be diverted into treatment. The IAP has started developing contact in this area and is undertaking further work with the Magistrates' Association.

39. The frequency of ministerial turnover, particularly at the Ministry of Justice, means that the IAP is now establishing constructive working relationships with the third Secretary of State and second Prisons Ministers in the last 18 months. These relationships are crucial, and the IAP is pleased that Rory Stewart MP, the Prisons and Probation Minister, has been keen to meet the Chair of the IAP and a range of stakeholders in his early months in the role. The IAP is committed to supporting him – and his ministerial colleagues at the Home Office and Department of Health – as they work to improve the safety of those in custody and meet their Article 2 human rights obligations.

A balanced focus across all custodial sectors

40. The IAP's attention over the last 18 months has predominantly focussed on improving safety in prisons. This was a deliberate decision, resulting from the significantly worsening conditions in prisons over the last few years, and the IAP's determination to assist Ministers and operational leads in reversing the trend of increasing deaths.

41. Building on this work and the reduction in the number of self-inflicted deaths, attention can be paid to how to maintain suicide prevention and keeping people safe in prison as a consistent priority. The IAP is keen to explore how best to reduce natural-cause deaths – in prison and other forms of custody. The IAP has worked closely with health colleagues given their role underpins all custodial

sectors and the police in the response to Dame Elish's review, and further substantive work in these areas can now be considered following a productive meeting with Simon Stevens, CEO of NHS England.

42. Deaths of patients detained in mental health establishments are a significant cause of concern, and the IAP is keen to undertake further work in this area. An area of focus will be the independent investigation of such deaths. Similarly, the IAP is conscious that there were four deaths in the immigration sector in 2017, up from one in 2016. The IAP looks forward to broadening its focus over the next 18 months, which will be shaped and developed by new panel members.

New panel members

43. The IAP has been fortunate to have had Panel members with such a strong and diverse range of skills working across the workstreams outlined earlier in this report. 2018 will see further change as the tenures of the existing Panel members come to an end, and new members are welcomed. While the new members are still to be announced officially, the successful candidates are all experts with a strong track record in their own professions, and the Chair looks forward to working with them to continue the IAP's efforts in existing areas, and develop new areas of focus.

Addressing repeat recommendations

44. As noted in the earlier section concerning the IAP's work, helping custodial sectors address the repeat recommendations made to them by scrutiny bodies is an important and potentially beneficial piece of work. If the IAP can help the sectors, and managers and staff in individual establishments, improve how they respond to such recommendations, there is scope to drive down the number of deaths in all forms of state custody.

45. However, this piece of work requires further analysis and consultation with investigators and regulators to develop it. The IAP is committed to working with Ministers and colleagues on the Ministerial Board in order to create a useful piece of work that can be used across all custodial sectors.

International comparators

46. The IAP has long held the view that greater consideration should be given to initiatives, best practice and research developed overseas. The issues being grappled with in custodial establishments across England and Wales are not unique, and there are opportunities for learning from other countries engaged in similar work. The IAP has undertaken discrete work looking at the situation in other jurisdictions and is grateful to ICPR at Birkbeck for its world prisons brief and to the Winston Churchill Memorial Trust, in partnership with the Samaritans, for establishing new international fellowships in suicide prevention. Building up a library of evidence from comparator countries can only help to ensure that Ministers and operational colleagues receive advice based on what is working across the world.

The Independent Advisory Panel

Chair

Juliet Lyon CBE

Juliet Lyon took up her post as chair of the Panel in September 2016. Previously, Juliet was the Director of the Prison Reform Trust and Secretary General of Penal Reform International. She is a visiting Professor in the School of Law at Birkbeck, University of London.

Panel Members

Stephen Cragg QC

Stephen Cragg is a barrister specialising in public law, and human rights and sits as a part-time judge for the mental health review tribunal. Stephen has been a member of the Independent Advisory Panel on Deaths in Custody (IAP) since 2014.

Dr Dinesh Maganty

Dinesh Maganty is currently Lead Consultant for intensive care for Birmingham and Solihull Mental Health NHS Foundation Trust Secure Care Services and a member of the National Clinical reference group for Health and Justice for NHS England. Dinesh has been a member of the IAP since 2014.

Dr Meng Aw-Yong

Meng Aw-Yong is a Forensic Medical Examiner and Medical Director for the Metropolitan Police, and currently works in Emergency Medicine at Hillingdon Hospital. Meng has been a member of the IAP since 2014.

Professor Graham Towl

Graham Towl is Professor of Forensic Psychology at Durham University, a visiting clinical professor at Newcastle University and a leading expert on suicide. He has previously worked as Pro Vice Chancellor at Durham University, Chief Psychologist at the Ministry of Justice and has been a member of the IAP since 2014.

Previous Panel Members

Matilda MacAttram (2014 – 2017)

Matilda MacAttram is founder and director of Black Mental Health UK (BMH UK), a human rights campaigns group established in 2006 to raise awareness and address the stigma associated with mental illness in the UK's African Caribbean communities. Matilda was a valuable member of the IAP from 2014 to 2017. We are particularly grateful for the contribution she made to the Harris Review.

Secretariat

Andrew Fraser, Head of Secretariat
Kish Hyde, Deputy Head of Secretariat
Angie Hinksman, Secretariat Support (until April 2017)