INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

END OF TERM REPORT
MARCH 2015

Contents

Advising the Ministerial Board, which brings together:

Ministry of Justice | Home Office | Department of Health

Forward from Chair of IAP

Welcome to the end of term report for the Independent Advisory Panel on Deaths in Custody. This report covers progress on the work of the Panel in its second term, from April 2012 to March 2015.

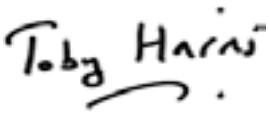
The purpose of the Panel is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales. We do this in partnership with stakeholders and by advising the Ministerial Board on Deaths in Custody which considers our recommendations. This report gives a full account of the Panel's engagement with both.

During this period there has been a worrying rise in the number of deaths in prisons, a significant number of which have been self-inflicted. A number of suggestions have been put forward to explain this increase, including such factors as a reduction in staff numbers, overcrowding, and a lack of purposeful activity. There is undoubtedly no single explanation, nor do any of these reasons explain the complexity of individual cases. Nevertheless, it is pleasing that NOMS is recruiting more staff and will be implementing a package of measures aimed at reducing self-inflicted deaths. We expect to feed into these measures designed to reduce the risk of self harm and suicide amongst prisoners.

There are lessons to be learnt from every death in custody, which if properly implemented could prevent the situation arising again. Up to now we have concentrated on analysing lessons learned from coroners' preventing future deaths reports and narrative verdicts. At a recent meeting, the Ministerial Board agreed that I should chair a group made up of those with responsibility for learning lessons in each of the custodial and commissioning organisations. This will be a valuable opportunity for the Panel to have an impact on identifying systematic ways of sharing relevant lessons across organisational boundaries and to ensure the evidence base is agreed upon and taken forward to prevent deaths.

Our second term has seen significant change for the Panel; we have lost experienced members of staff from both the secretariat and the Panel. However, we also welcomed five new members last April and this has refreshed our expertise. We are adapting our projects and priorities to make best use of our new members. Several of the organisations we seek to influence have also undergone significant change in this period and we have adapted the focus of our work accordingly. The Panel continued delivery on its annual work programmes; published research and analyses; and made recommendations to the Ministerial Board.

As an arms length body, the IAP is to be formally reviewed at the beginning of the next financial year. I look forward to contributing to that review and to shaping an effective future for our work.



Lord Toby Harris
Chair of the Independent Advisory Panel
on Deaths in Custody

Introduction

Setting the scene

Members of the IAP – appointments during the term

Three Panel members retired from the IAP during this term – Simon Armson, Professor Stephen Shute and Dr Peter Dean – who all left in April 2014. They were replaced by five new members:

- **Matilda McAttram**, founder and director of Black Mental Health UK (BMH UK);
- **Dinesh Maganty**, Lead Consultant for intensive care for Birmingham and Solihull Mental Health NHS Foundation Trust Secure Care Services;
- **Meng Aw-Yong**, Forensic Medical Examiner and Medical Director for the Metropolitan Police, currently working in Emergency Medicine at Hillingdon Hospital;
- **Stephen Cragg**, a barrister specialising in public law and human rights; and
- **Graham Towl**, Pro Vice Chancellor and Deputy Warden at Durham University.

In addition, appointments of the Chair and the three existing Panel members – Deborah Coles, Philip Leach and Richard Shepherd – were extended until the end of September 2015 to enable completion of their work on the Harris Review of self-inflicted deaths in NOMS custody of 18-24 year olds and the Triennial Review of the IAP.

More information about the panel members can be found on the IAP website by clicking **here**.

Deaths in custody in the period 2012-2014

Since the Panel published its first statistical analysis of all recorded deaths in state custody in 2011 it has become more familiar with the datasets produced by the organisations[1] and with the important differences between the populations in each of the settings. It is clear that each custody setting has different population sizes, duration of detentions; classification and data collection methods, all of which have imposed constraints on comparing trends.

Deaths in prisons and those of patients detained under the Mental Health Act (MHA) represent nearly 90% of all deaths in custody.

There were fluctuations in the number of deaths from year to year. In prisons the numbers rose from 215 in 2013 to 243 deaths in 2014[2]. These included:

- 84 apparent self-inflicted deaths, up from 75 in 2013, representing a 12% increase
- 141 deaths due to natural causes, up from 131 in 2013 (8%)
- 3 apparent homicides, down from 4 in 2013
- 15 other deaths, 14 of which were yet to be classified awaiting further information (as of January 2015).

Meanwhile we reported on deaths of detained patients (in England and Wales) as follows[3]:

- 236 deaths of detained patients in 2011/12, 275 deaths in 2012/13 and 198 in 2013/14
- The most common causes of death, where known, were pneumonia, heart disease and pulmonary embolism
- The total number of reported deaths by unnatural causes for detained patients' deaths rose from 36 in 2011/2012 to 48 in 2012/13, then returned to 36 in 2013/14.

[1] National Offender Management Service (NOMS), Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW), Independent Police Complaints Commission (IPCC), Immigration Enforcement, Approved Premises (AP) and the Youth Justice Board (YJB).
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399071/safety-in-custody-to-sept-2014.pdf
[3] http://iapdeathsincustody.independent.gov.uk/news/cqcs-mental-health-act-annual-report-201314/

Changing organisational structures and purpose

There have been significant changes to the structure and oversight of the NHS and national policing context during this term. The Panel has adapted a range of its priorities to the new organisations and has developed positive relationships with NHS England; the College of Policing and new national policing leads for custody and mental health.

NHS England

- From April 2013, NHS England became responsible for commissioning of all health services (with the exception of emergency care, ambulance services and out-of-hours services) for people in prisons (including youth offender institutions) and immigration removal centres (IRCs) in England. Ten of the 27 area teams have the responsibility for the commissioning of healthcare services in these settings
- The range of services which are directly commissioned for prisons include secondary care services (hospital care), public health, including substance misuse services in addition to the continued commissioning of medical, dental and ophthalmic services
- A partnership agreement between NHS England, NOMS and Public Health England is in place on the strategic intent and joint commitment to work together for the purposes of co-commissioning and delivery in health care services
- A framework agreement made between NHS England and Immigration Enforcement in December 2013 applies to all areas of criminal justice health commissioned by NHS England in IRCs and other accommodation managed by Immigration Enforcement. The agreement outlines the basis of co-operation and collaboration between NHS England and Immigration Enforcement and is designed to ensure that the relationship is effective in order for the organisations to work together.

College of Policing

The College of Policing is the professional body for policing with a mandate to set standards in professional development, including codes of practice and regulations, to ensure consistency across the 43 forces in England and Wales, as well as a remit to set standards for the police service on training, development, skills and qualifications.

In June 2014, the College of Policing, IPCC and HMIC published a concordat[4] setting out how they will work together to achieve the highest possible standards in policing. The concordat sets out the three organisations' respective roles in relation to standards, good practice and continuous improvement in policing, in order to ensure public confidence.

[4] http://www.college.police.uk/About/Documents/Concordat_between_HMIC_College_of_Policing_and__IPCC.pdf

Progress on IAP priorities

Contribution to the Ministerial Board on Deaths in Custody

The Panel has made 45 recommendations to the Ministerial Board since 2009 of which 19 have been implemented, while another 18 have been accepted either partially or fully and are being progressed. Three recommendations were withdrawn.

Lord Harris attended all nine of the Ministerial Board on Deaths in Custody meetings which were held during the Panel's second term. He was accompanied by Panel members when they were making recommendations in relation to their specific workstreams. The main areas of work reported to the Ministerial Board were as follows:

- The Panel commissioned research about the impact of preventing future deaths reports (formerly Rule 43 reports) following a death in custody to ascertain how effective organisations efforts had been in implementing lessons learned. Lord Harris presented the findings to the Board in October 2012, explaining that the IAP thought that learning from deaths in state custody must be made a higher priority for all custodial organisations. They hoped that the appointment of the Chief Coroner would lead to a significant improvement in how learning was analysed and implemented to lead to sustained improvements. The researchers found that those involved in implementing learning in each of the organisations needed a better understanding of relevant evidence about how to effect change as a result of Rule 43 letters. This would ensure that the learning made a real difference to reducing future deaths in custody by supporting practitioners to make changes that could be sustained over time, rather than re-stating or amending guidance and policy
- The IAP has highlighted concerns that organisations could do more to understand the evidence base for effective ways to enable staff to learn lessons to prevent future deaths. This will enable them to ensure the lessons they disseminate effect real change. In February 2015, Lord Harris gained the Board's approval to coordinate a meeting of those with responsibility for learning lessons in each of the services and regulatory bodies to identify how cross-sector learning might be identified. They will also discuss best practice in organisational learning to encourage the use of a sound evidence base about 'what works' to promote staff behaviour change to make custodial environments safer. The Panel will be taking this forward in May 2015
- Following concerns raised in the course of its work on information flows through the criminal justice system, the Panel agreed with HMIP that they should undertake a thematic analysis of Person Escort Record (PER) forms. The outcome of this analysis was presented to the Board in October 2012 by Nick Hardwick, HM Chief Inspector of Prisons. Further work on the PER project can be found later in the report
- In June 2013 the Panel presented an analysis of Serious Untoward Incident (SUI) reports into deaths of detained patients. This highlighted that there was no system to investigate promptly, transparently and effectively the deaths of detained patients. The Panel recommended that NHS England – with input from CQC and the Chief Coroner – should produce guidance for mental health trusts, which provided clear and consistent guidance on how trusts should undertake investigations following the death of a detained patient. The Board accepted the recommendation. More detail about this workstream can be found later in the report

- The Panel presented its common principles for safer restraint to the Ministerial Board in June 2013. Lord Harris acknowledged the different challenges each custodial sector faced when using restraint, but advised that these principles were a first step towards achieving consistency. It was for the relevant organisations to consider how to apply the principles in their existing frameworks. The Minister confirmed the Board's endorsement of the principles. The IAP followed this up by writing to organisations asking them to implement the standards using their own policies and communication methods.

IAP workstreams

i. Article 2 Compliant Investigations

Independent investigations of deaths of detained patients

Following its recommendation to the Board in June 2013 that NHS England – with input from CQC and the Chief Coroner – should produce guidance for mental health trusts which provided clear and consistent guidance on how trusts should undertake investigations following the death of a detained patient, the Panel had a series of meetings with NHS England Patient Safety about their guidance.

The Panel submitted a formal response to the NHS England draft Serious Incidents Framework (SIF) in September 2014, welcoming the improved focus on family contact, their emphasis on the importance of learning from deaths and governance points including the need for investigations to be undertaken by staff separate from the commissioning and provider organisations. However, the Panel was concerned that the guidance fell within the broader scope of serious incidents and thought the need to focus on Article 2 compliance would be lost.

Lord Harris met the NHS England Director of Patient Safety in November 2014. The Director provided reassurance about NHS England efforts to address weaknesses in learning from deaths of detained patients and the system wide approach to improving safety, such as Patient Safety Collaboratives. However, since the Panel's original submission, the document was re-drafted following announcements about the restructuring of NHS England commissioning, meaning that independent investigations would need to be commissioned by Clinical Commissioning Groups (CCGs) instead of regional teams. The Panel raised concerns that this would be a barrier to system wide learning. The Serious Incidents Framework has since been published and the Panel will continue to work

with NHS England about how to work towards Article 2- compliant investigations.

PPO investigations in secure children's homes (SCHs)

In its second term, the Panel continued to press Department for Education (DfE) to implement the recommendation that would enable PPO investigations of deaths of children detained in secure children's homes (SCHs). The recommendation was made in June 2011.

The Panel attended a further meeting with the DfE, Prison and Probation Ombudsman (PPO) and the Youth Justice Board (YJB) in December 2014. This was arranged following DfE's proposal to the Ministerial Board in October 2014 that the PPO should investigate deaths in secure children's homes only of children placed there for justice purposes. Alongside other Board members, the Panel was concerned that all children placed in SCHs should be covered. At the Ministerial Board in February 2015 DfE confirmed that amendments would be made to the Children's Home Regulations requiring SCHs to enable PPO investigations. The Regulations are due for implementation from April 2015. Despite concerns about the length of time it has taken to implement this recommendation, particularly given that approval was received from the Minister for Children & Families in 2012, the Panel welcomes DfE's recent work to amend the regulations and their commitment to work with PPO on developing a Memorandum of Understanding setting out their responsibilities in relation to learning any future deaths.

ii. Use of force

Common Principles on Use of Restraint

In 2012 we reported that the Panel would be developing common principles on the use of restraint in order to bring about an improvement in operational practices across the custodial and health and care sectors where patients are detained in order to reduce the number of restraint related deaths in the future. During 2012, the IAP held meetings with leaders from the custodial settings and the Independent Restraint Advisory Panel (IRAP) to refine the principles. Whilst these discussions were necessary in shaping the direction of the principles, it was not until the Panel's formal consultation in January 2013 that detailed feedback was received from some key organisations. This showed significant divergence on some points such as the underlying principle of working towards restraint reduction.

The Panel's view was that restraint reduction was a relevant aspiration for all organisations and they aimed to publish common principles which, if followed, would be of value in making restraint safer and preventing restraint related deaths.

The principles were published in July 2013. They cover expectations for restraint training; management of restraint incidents; medical conditions relating to the use of restraint and governance procedures such as de-briefing and data collation. After initial concerns from organisations, recent feedback has been positive and the Panel expects that they will be complying with the principles and incorporating them into policy.

Another obstacle to gaining acceptance of the principles, as a document that could be put into operation in all settings, had been questions about their applicability to places where patients are detained under the Mental Health Act. The Panel was, therefore, pleased that the Department of Health (DH) announced its Positive and Safe Programme in 2014. This is a two year programme designed to reduce the use of restrictive interventions in health and care settings. DH guidance published in April 2014 provides the framework for services to develop a culture change in which the use of restrictive interventions is always a last resort and a commitment to work towards ending prone restraint.

Restraint during immigration removal

The IAP has been following the development of the Home Office bespoke training package for the immigration escort process which was commissioned following the death of Jimmy Mubenga in October 2010. His death occurred as a result of an unapproved control and restraint technique being used while being removed from the UK, and a lack of medical attention while on the flight. NOMS conducted an initial review immediately after Mr Mubenga's death and concluded that the existing control and restraint techniques were not fundamentally dangerous but could be improved. UK Border Agency commissioned NOMS to develop a bespoke restraint system and appointed an Independent Advisory Panel for Non-Compliance Management to assess the restraint techniques, quality and safety of the proposed restraint system. Their report, published in April 2014, made several recommendations, all of which were accepted by the Home Office, and endorsed the proposed training and equipment.

The new training is focused on managing people through the escort journey rather than just the application of restraint techniques and has been designed with a focus on specific scenarios, with staff being taught in a facility that simulates the escort journey.

The Panel fed back to the Home Office that the information in the HOMES training manual should be placed in the public domain and that there should be monitoring of the use of force during escorts and this should also be publicly available. An update on this is anticipated from Immigration Enforcement at the next meeting of the Ministerial Board on Deaths in Custody in June 2015.

iii. Information Flows through the Criminal Justice System

Information Sharing Statement

The IAP's Information Sharing Statement (ISS) was endorsed by the Information Commissioner and the Ministerial Board in 2011 and by the General Medical Council in March 2012. The statement was then circulated to service leaders in September 2012 for onward dissemination to staff on the ground.

In its second term, the Panel commissioned the University of Greenwich to conduct a preliminary evaluation of the impact of the ISS following its dissemination in 2012. Service and operational leaders who had originally been sent the statement (or those for whom the statement was relevant) across the sectors were interviewed to explore how information typically flowed in the organisation, how the ISS was disseminated, and whether they believed that the ISS had an impact on practice.

The evaluation found that there was great variation across the organisations in the methods of cascading the information and it was not easy to decipher whether practitioners had seen it and acted upon it.

The Ministerial Board agreed in February 2014 that the IAP should follow up agencies to review how they disseminated the ISS and how it would be incorporated into guidance. Between July and September 2014, the Chair met leaders in NOMS, Immigration Enforcement, NHS England and the College of Policing. He was pleased to note that each organisation was making progress in building the statement into their policies and guidance although there continued to be a lack of clarity about how lessons were learned, such as the need to share information, and how they were being integrated into practice.

The Panel have recently provided feedback on information sharing and risks of self-harm to the NHS England Health and Justice Information System (HJIS) re-procurement project. The project, which is managed in partnership with NOMS, aims to deliver IT integration between community and detention settings for the first time and involves re-procurement and improvement to SystmOne. It will do this by building on SystmOne, expanding it to include all places of detention in which NHS England commissions services, and will connect these systems to the wider community NHS. The system includes the requirements of the ISS and will allow the creation, maintenance and transfer of a single medical record for all patients across the residential estate. HJIS and the Panel will continue to work together as the project develops.

Person Escort Record

Following discussions with stakeholders and after visiting a Young Offenders Institution (YOI) in 2010, the Panel was concerned that in many cases there was insufficient detail (or out of date information) about the risk of self-harm and/or suicide to enable the recipient of the Person Escort Record (PER) to effectively manage the risks presented by the detainee.

On behalf of the Panel, Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Constabulary (HMIC) carried out a *thematic review*[5] which was published in October 2012. Its recommendations included the need to move towards an electronic PER that would be easier to read, complete, and more open to quality control; that further research should be carried out in prisons and YOIs to explore the extent to which PERs were effective in ensuring good risk assessment and care planning and NOMS should establish mechanisms to encourage Prison Escort and Custody Services (PECS), police services, prisons and the PECS contractors to work together regionally to improve the quality and flow of information about self-harm.

Some progress has been made with implementing Regional Forums to encourage multi-disciplinary learning about information sharing and to improve the quality of information provided on Personal Escort Records (PERs), although it is operating as a pilot in just one region to begin with. NOMS has worked with partners to design a new version of the PER form which they hope to pilot in a range of establishments during 2015 and evaluate in early 2016. The Chair has written to HM Chief Inspector of Prisons outlining his view that there is more to do amongst the agencies on joint working at regional level and inviting him to discuss the issues in more detail.

iv. Natural cause deaths of detained patients

In March 2011, the Panel made a number of recommendations designed to improve the physical health of detained patients, including one requiring further analysis by the CQC to examine the reasons for the high numbers of deaths from myocardial infarction (MI) and pulmonary embolism (PE) amongst those detained under the MHA. The Panel was involved in a series of meetings with the Health and Social Care Information Centre (HSCIC), CQC and DH to discuss how this could be achieved. In 2014 the HSCIC provided a link between data sets (the Mental Health Minimum Data Set and Hospital Episode Statistics) to CQC, which would be required to support this work.

However, it has since been agreed that instead of a standalone analysis, the CQC will embed this topic into their system of Intelligent Monitoring of mental health providers by developing an indicator of premature mortality that will inform risk based inspections. This will ensure that they will be alerted to Trusts where the level of expected mortality due to natural causes (such as MI and PE) is exceeded. The CQC would then undertake regulatory action, if required. The CQC is working in collaboration with NHS England to develop the indicator.

[5] http://webarchive.nationalarchives.gov.uk/20130128112038/http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/per-thematic.pdf

Although the original recommendation was for a re-analysis of the data, the Panel is hopeful that embedding an indicator into CQC Intelligent Monitoring will have an ongoing impact on improving physical healthcare of detained patients. The Panel welcomes this development and the positive relationship they have developed with CQC in pursuing improvements to reduce deaths of detained patients.

v. Mental health and deaths in custody

Mental Health Literature review

The Panel identified a need to review how mental disorder amongst detainees relates to self-inflicted and natural cause deaths in all custodial settings. As part of its contract to provide research and analysis for the Panel, the University of Greenwich commenced work on a literature review in 2013 with the aim of identifying priorities for future work.

The review was not as comprehensive as the Panel had hoped, particularly given the recent developments on mental health crisis care. It found studies that mainly focused on detainees in prison and police custody settings. The University of Greenwich advised that although there were many reports on the prevalence of mental health problems amongst offenders and those in prison and police custody; and some evidence to show the relationship between those mental health problems and deaths in custody, the relationship was complex and could not be systematically broken down to inform specific actions to improve risk management. In order to take the work forward, the Panel then asked the University of Greenwich to explore the small amount of literature they had found on staff knowledge and attitudes towards mental health and the extent to which this led to improved care for detainees. The Panel's report and the literature review can be found here[6].

The Panel decided, given the complexity of the relationship between mental health and deaths in custody, that a first step would be to take action on the link between improving staff attitudes to mental health and improved care. They subsequently hosted a roundtable discussion with key organisations on 23 March, including the national policing lead on mental health; DH: NOMS; HMIC; the College of Policing; immigration; Home Office and MIND to discuss staff training and how to support their own mental wellbeing. This was a positive meeting and there was consensus about the importance of staff supervision, in addition to line management, in order to build resilience and improve staff mental wellbeing. There was also recognition of the importance of targeted, skills based, training for custodial staff and police officers. MIND presented information about their innovative Bluelight project.

vi. Family liaison

Following two listening events with bereaved families in its first term, the Panel recommended that mental health trusts should have procedures in place for ensuring good quality family liaison with bereaved families.

At their stakeholder consultation day in March 2012 the Panel held a workshop on family liaison following investigations of deaths in custody. This confirmed that many services had developed good practice in working with families, although there were inconsistencies between organisations about the extent to which families were provided with information flowing from investigations.

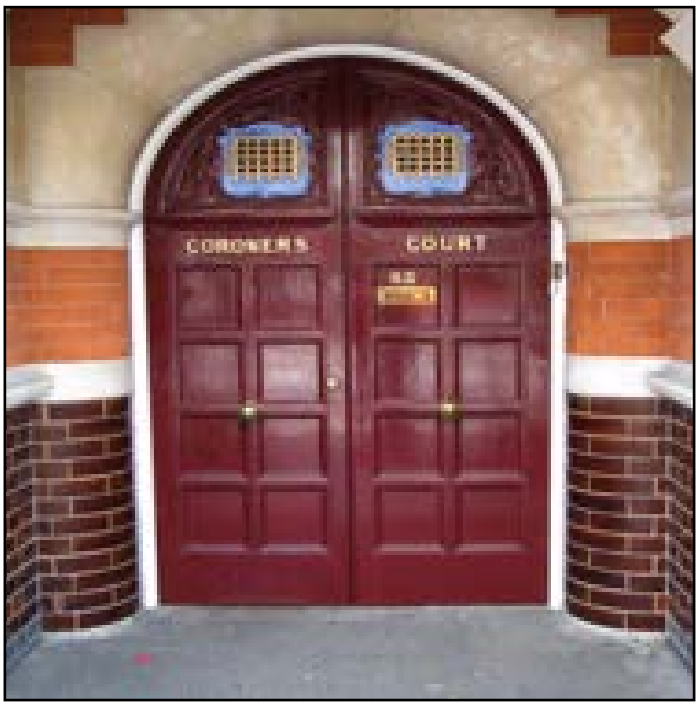
The consultation informed the Panel's common standards for liaison with bereaved families which were developed in partnership with the custodial organisations, DH and investigative bodies. The standards were intended as high level principles to guide the design and delivery of family liaison following a death in custody. The IAP published the final version of the *family liaison common standards and principles*[7] in February 2013.

[6] http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/deaths-of-patients-detained-under-the-mental-health-act-mha/
[7] http://iapdeathsincustody.independent.gov.uk/news/family-liaison-common-standards-and-principles/

The standards were communicated to practitioners in each of the organisations to be incorporated into existing policies and information leaflets in due course. The standards were endorsed by the Ministerial Board on Deaths in Custody at their meeting in February 2013 and organisations were asked to outline how they intended to implement these standards.

This will be an important area to revisit in the Panel's next term, as there continue to be concerns about the arrangements and quality of family liaison services following deaths of detained patients.

vii. Timeliness and learning from inquests



During its first term the Panel undertook research in conjunction with the Coroners' Society on the extent and reasons for delays in death in custody inquests, which inhibited timely learning. The paper[8] was presented to the Ministerial Board in October 2011 and contained a series of recommendations aimed at reducing the delays and to ensure effective monitoring of standards. These recommendations were agreed by the Board including the need for coroners to be trained in case management to prevent avoidable delays.

Building on this, the Panel commissioned a study in its second term, on the impact of Rule 43 letters on learning to prevent future deaths[9]. The Panel asked researchers (Mendas) to consider how Rule 43 letters were written, how organisations dealt with them and how they were used as tools for learning. Lord Harris presented the report to the Ministerial Board in October 2012 and drew attention to the following:

- The Chief Coroner's office should develop a fully searchable, publicly accessible, database of all death in custody Rule 43 reports, which included sufficient information to identify themes and trends for inclusion in the annual report to Parliament. The information should be accessible to custodial organisations and other relevant organisations for the purposes of learning and research
- Training for coroners should include guidance about when Rule 43 reports should be made to promote greater consistency in their approach to deaths in custody inquests.

Shortly after his appointment, the Chief Coroner attended the IAP meeting in December 2013 and advised that he had undertaken a number of actions to improve delays in the system as well as the quality of Rule 43 reports (now known as Preventing Future Deaths reports). These included identifying the areas with the largest backlogs and holding meetings with them to address the delays, as well as training days and seminars with Coroners. He was also in the process of issuing guidance on pre-inquest hearings, which emphasised the importance of communication with bereaved families.

The Panel was pleased to note that by summer 2014 the Chief Coroner's Office had started to publish Preventing Future Death (PFD) reports and responses on its website. The Chief Coroner's Office did not have sufficient resources, however, to conduct an ongoing analysis of common themes arising from the PFD reports. The Panel commenced scoping activity as to how it might fulfil that role, but work stalled pending

[8] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Delays-in-DiC-Inquests-IAP-Cross-Sector-Learning.pdf
[9] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/10/IAP-Impact-of-R43-analysis.pdf

discussions at the Ministerial Board about how organisations should work together to identify cross sector learning.

viii. Statistical analyses of all deaths in state custody – reports on data from years 2012 and 2013

The Panel published its third and fourth statistical reports into deaths in custody during this term. Both reports were prepared by the University of Greenwich and covered the period between 2000-2012 and 2000-2013. Professor Graham Towl, who joined the Panel in April 2014, provided guidance on the publication of data for 2013.

The statistical analysis data for 2012[10] reported that there had been a total of 549 deaths in state custody in 2012. A breakdown by cause of death of these shows that:

- 67% (368) were natural causes – 65% (239) of which were deaths of patients detained under the Mental Health Act;
- 21% (115) were self-inflicted deaths
- 7.3%% (40) were 'cause of death unknown', 37 of the 40 were patients detained under the Mental Health Act;
- 1.8% (10) of deaths were 'awaiting further information' before classification
- 1.8% (10) were 'Other non-natural deaths' including ODs
- 0.9% (5) were classified as 'Other – Accidental'
- 0.2% (1) was death caused by another person
- A higher proportion of the Black (6.2%), Not Known (7.1%) and 'Other' group (1.2%) died in mental health settings compared to prison (5.7% and 0% respectively).

The statistical analysis report for 2013[11] included three-year average figures and rates by 100,000, where population data was available. This helped the Panel to draw sound conclusions about how deaths in custody have changed over time and the use of rates by 100,000 will enable them to make comparisons to deaths in the community in due course.

The report provides detailed analysis covering the range of protected characteristics of age, gender and ethnicity. In addition to these, it contains a breakdown of the figures including the average number of deaths across different custodial settings; and rate of deaths by cause including restraint related deaths and a thematic analysis of self-inflicted deaths.

The report showed that there were:

- 7,630 deaths recorded in total for the 14 years from 2000 to 2013; this is an average of 545 deaths per year
- 523 deaths in custody in 2013, 30 less than in 2012
- From 2000-2013 approximately 60% of deaths have been of detained patients and 30% have been of prisoners
- The number of deaths of patients detained under the Mental Health Act reduced to 282 (from 341 in 2012)
- There were 215 deaths in prison and YOIs, which included 75 self-inflicted deaths (SIDs)
- 63% (331) of all deaths in 2013 were due to natural causes. 190 of these deaths were of detained patients
- 23% (119) of the all deaths were self-inflicted. The number of self-inflicted deaths in prison in 2013 was 75, compared to 60 the previous year. There were 42 SIDs of detained patients in 2013, which is lower than 53 recorded in 2012
- Most self-inflicted deaths in prisons were of males (73 of 75 in 2013) compared to 28 male SIDs and 14 female SIDs of detained patients in the same year.

[10] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/IAP-Statistical-analysis-of-recorded-deaths-2000-to-2012-Publication.pdf
[11] http://iapdeathsincustody.independent.gov.uk/news/iap-publishes-statistical-analysis-of-deaths-between-2000-and-2013/

The Panel continues to receive quarterly updates from a range of providers about deaths in all state custody. They are also working with CQC to improve the quality of the data provided for the annual analysis. It has not been possible for NOMS to provide up to date statistics about deaths in prisons due to constraints relating to National Statistics accreditation, so the Panel refers to published Safety in Custody statistics instead.

Stakeholder engagement

Since the mid-term report[12] the Panel have been involved in:

- Contribution to development of terms of reference for the HMIC thematic inspection of vulnerable people in police custody
- Submitted a response to the consultation on Authorised Professional Practice (APP) for police custody which now includes a requirement to record use of force following recommendations from the Panel. The revised APP Detention and Custody is scheduled for publication in June 2015
- Published quarterly e-bulletins[13] during this term, updating all members of the practitioner and stakeholder group on progress with the work programme, relevant publications and learning on deaths in custody as well as a summary of the IAP consultation event in March 2014
- The Secretariat has represented the Panel at several meetings of the National Suicide Prevention Strategy Advisory Group and Bradley Group meetings
- In addition to regular meetings with co-sponsors of the Ministerial Council, the Chair of the IAP has undertaken a series of bilateral meetings during this term. During the past year alone he met Kate Davies (Head of Public Health, Armed Forces and Health & Justice Commissioning); Dru Sharpling (HM Inspector of Constabularies); Caroline Hacker (Head of Mental Health Policy, CQC), Nigel Newcomen (PPO), Mike Durkin (Director of Patient Safety, NHS England). The Chair also had a bi-lateral meeting with Andrew Selous, Minister for Prisons, Probation and Rehabilitation on 19 November
- Members of the Panel have spoken at a range of conferences including the Prison Healthcare Conference (Royal Society of Medicine); the All Party Parliamentary Penal Affairs Group; and the

[12] http://iapdeathsincustody.independent.gov.uk/news/iap-mid-term-report-2014/
[13] http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/e-bulletins/

fifth anniversary of the UK's National Preventive Mechanism and Death in Custody Conference (organised by McKay Law and Advocates)

- The Chair met Sue Hemming, Crown Prosecution Service (CPS) Head of Special Crime and Counter Terrorism Division in October 2014 in order to understand in more detail the CPS processes for investigating deaths in custody; the issues relating to corporate manslaughter prosecutions and their arrangements for family liaison
- The Chair of the IAP spoke at the Home Office and BMHUK joint conference on mental health and policing in October, and delivered two workshops during the day
- The Chair spoke at INQUEST's parliamentary event to launch their report: *Mental health deaths: An investigation framework fit for purpose* in February 2015. Members of the Panel and the secretariat also attended the event
- The Panel contributed to the EHRC Inquiry into Adult Deaths in Detention, and have met a range of organisations to ensure the HMIC, IAP, Harris Review and EHRC work on deaths is as coordinated as possible. Lord Harris also spoke at the launch of their report[14].

Stakeholder event March 2014

The third IAP stakeholder consultation event took place in London on 27 March 2014. The Panel were pleased to note that over 100 stakeholders attended the event. The event was opened by Lord Harris, Chair of IAP and the Prisons and Rehabilitation Minister, Jeremy Wright, gave the key note speech.

Cleanbreak gave a series of short performances to highlight issues and engage attendees on the subject of mental health and deaths in custody. The actors stayed in role during the themed break-out sessions to talk about their experiences of custody as a way of promoting open discussions and to explore the issues in greater depth. The day was rounded off with an open plenary session for delegates to feedback on their thoughts on the day and to raise issues and concerns and items as potential future work for the Panel.

Feedback from the event was positive and several delegates put forward their ideas for research for the Panel to explore.

[14] http://www.equalityhumanrights.com/publication/preventing-deaths-detention-adults-mental-health-conditions

Future priorities for the IAP

New areas:

a. Taser and use of force monitoring

The use and discharge of Taser by police forces is becoming more prevalent, with far more police officers routinely carrying Tasers. In 2014 the IPCC commenced a project on the use of force, to which Panel members Philip Leach and Richard Shepherd are contributing. Use of Taser will be covered under the terms of reference of the study which is due to report in July 2015.

The Panel is also in touch with the Metropolitan Police Service (MPS) Taser Reference Group, and attended its expert session in March to contribute to ideas as to how its use could be monitored. The Panel is concerned about use of Taser during police attendance at mental health wards as well as reports about it being discharged in confined spaces such as custody suites. They will be scoping a piece of work to ensure they are able to respond on this topic which attracts high public interest.

b. Equalities

The Panel met in November 2014 to take stock and update the existing scoping paper on equalities. Specific activity on this project was defined including the plan to undertake a gap analysis of data on protected characteristics in relation to deaths in each sector and to identify the data collected on those brought under liaison and diversion service. An equalities statement will be published shortly and the Panel is considering activity such as hosting expert workshops to which academics will be invited to explore the literature on disproportionality and use of force; and to identify potential recommendations that lead to improved use of de-escalation techniques by the police with over-represented groups such as black males who are vulnerable.

Governance and funding

The IAP's work is funded jointly by the Home Office, Department of Health and NOMS (for the Ministry of Justice). This funding pays for staff in our secretariat; honorariums received by Panel members and research. They also have a small amount of funding to maintain its independent website and for events.

Triennial Review

The IAP will be subject to a Triennial Review (TR) in 2015/16, which has been taken into consideration in design of their annual work programme.

A Triennial Review is the Cabinet Office mandated process for reviewing the function of Non-Departmental Public Bodies (NDPBs) and Arms Length Bodies (ALBs). The purpose of these reviews is to provide a robust challenge of the continuing need for individual NDPBs – both their functions and their form; and to review the control and governance arrangements in place to ensure compliance with the principles of good corporate governance. The TR may be used to look more widely at the terms of reference of the Ministerial Council. It will be undertaken independently of co-sponsors by the MoJ Arms Length Bodies Governance Division who will liaise at an early stage with the Panel and co-sponsors to ensure they are involved appropriately.

The Review is likely to commence in July 2015. It will be followed by a submission to Ministers with the proposed changes and the outcome of the TR will be communicated by Written Ministerial Statement in due course.

Co-sponsors will seek Ministers' views on options for recruitment of a new Chair of the IAP (Lord Harris's term ends at the end of September) once there is more certainty about continuation of the IAP. Three Panel members are also due to end their terms at the beginning of October 2015; their recruitment will need to take place once a new Chair is appointed as he/she would expect to be involved in the selection.

A note on the scope of the IAP

Mental Capacity Act, individuals subject to Deprivation of Liberty Safeguards (DoLS)

The purpose of the IAP on Deaths in Custody 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. This 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 will also apply to the deaths of those detained under the Mental Capacity Act in hospital. This follows a Panel meeting with the CQC to discuss their role in monitoring the use of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). CQC had seen a 10% increase in applications in a year and were hoping that there would also be an improvement in the notifications of deaths. This follows the Supreme Court judgment in *P v Cheshire West and Chester Council and P and Q v Surrey County Council*. The Panel believes this judgment redefines the concept of 'detention' to include individuals subject to the Mental Capacity Act.

The Panel also notes the Chief Coroners' recent guidance to coroners about the *Deprivation of Liberty Safeguards*[15] in which he states that any person subject to DoLS is in state detention for the purposes of the Coroners and Justice Act 2009, and the coroner should undertake an investigation into the deaths of such persons. The Panel explored this at their meeting in March and has included influence of data collection in its work programme in 2015/16.

[15] http://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf

Deaths Immediately following release or discharge – IPCC figures

Although outside the remit of the IAP, the Panel were concerned about the *IPCC report on deaths during or following police contact 2013/2014*[16] reports that the number of apparent suicides following custody has increased from 65 fatalities in 2012/13 to 68 this year. This is the highest figure recorded in this category since 2004/05. Reporting of these deaths relies on police forces making the link between an apparent suicide and a recent period of custody. The overall increase in these deaths may therefore be influenced by improved identification and referral of such cases.

Two-thirds of individuals (45) were reported to have mental health concerns and three of these had been detained under the Mental Health Act 1983 prior to their death. Other mental health concerns included previous suicidal thoughts, suicide attempts, personality disorders or depression.

32 apparent suicides occurred on the day of release from police custody, 24 occurred one day after release and 12 occurred two days after release.

[16] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/11/Deaths-during-or-following-police-contact-Statistics-for-England-and-Wales-2013-14.pdf

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