

## Message from the Chair of the Panel



Welcome to the spring 2017 edition of the IAP bulletin. I was pleased to be appointed IAP Chair in September 2016, and I look forward to working with you in the vital challenge of reducing the number and rate of deaths in all forms of state custody.

I have spent my first six months meeting prisoners and prison staff, patients and clinical staff and those in police custody suites, Ministers, operational leads and wider stakeholders. This half-year has been one of significant change with new ministerial teams now working on the Government's efforts to reduce deaths in custody. While any deaths in health, immigration and police custody continue to be areas of concern, the Panel is particularly disturbed by the increase in deaths in the prison estate and are working closely with colleagues in HM Prisons and Probation Service in their efforts to reverse the trend. The recent announcements in the White Paper of more staff and a greater focus on meaningful interactions with prisoners is to be encouraged, but continuing efforts are needed to reverse the current increase in deaths.

The level of change in the departments makes the primary role of the IAP – providing advice to Ministers on the best means of reducing deaths in state custody – so important. I am determined to make sure the IAP makes a significant contribution to the substantive efforts everyone in this area is making, and this means acting strategically and being selective about the areas where the IAP can help. One of these is the recent rise in the deaths of women in prison – I have written to a number of stakeholders to ask their advice on the best means of halting this increase to provide the content for a briefing to Ministers. You can find information on other areas of the IAP's work later in the bulletin.

I am clear that the IAP must listen directly to families and those in the criminal justice, immigration and health systems. The IAP intends to run a session with bereaved families in spring, and open conversations with those in state custody will continue to inform all the work we undertake. I hope that you find this bulletin informative, and I look forward to working with you throughout 2017 as we seek to prevent further deaths in state custody.

As always, if you have any questions, please contact me or the Secretariat on [iapdeathsincustody@noms.gsi.gov.uk](mailto:iapdeathsincustody@noms.gsi.gov.uk).

**Juliet Lyon CBE**

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## The Prisons and Courts Bill

The Prisons and Courts Bill is currently going through Parliament. The original text of the Bill contained content which, applied appropriately, could play a significant role in safeguarding people in prisons. The measures of the Bill set out a revised governance framework for prisons where the Justice Secretary will account to Parliament for progress in reforming offenders, and a strengthened inspectorate and ombudsman will provide sharper external scrutiny of the system. This framework will be supported by

- new standards and league tables
- a new commissioning structure
- new powers for governors.

The strengthening of the powers of HM Inspectorate of Prisons and the Prisons and Probation Ombudsman are to be particularly welcome. Strong and effective oversight of the system is essential to both identify and articulate its failings, and the ways to mitigate them. Putting the Ombudsman's office on a statutory footing is something that has been sought for many years, and it sends an important message on the importance of their role.

## The White Paper on Prison Reform and Harris Review

The IAP was pleased to see the publication of the Government's recent White Paper - [Prison Safety and Reform](#) – which seeks to counter the rising violence, self-harm and suicide currently experienced across the prison estate. The IAP welcomes the inclusion of many of the key themes and recommendations from the IAP's Harris Review [Changing Prisons, Saving Lives](#).

While the report focussed on young male prisoners between the ages of 18-24, many of the recommendations are applicable across the entire prison estate and we are pleased to see them being introduced, such as

- the establishment of an overarching statutory purpose of the prison system, with a clear vision of what it is there to achieve
- the provision of a dedicated officer for six prisoners who can engage with them one-to-one and who has the authority to take forward actions on their behalf
- The commitment that staff will be provided with the right tools, training and support to enable them to do their job effectively
- The commitment that **NOMSHMPPS** will be increasing the number of prison officers
- the Government's commitment to create a reformed estate that will be less crowded, better organised, more effective and comprise modern, fit for purpose accommodation
- the commitment that **NOMSHMPPS** will work closely with the police, Crown Prosecution Service and others across the criminal justice system to ensure a robust and swift approach to tackling criminality in prison.

The IAP will work closely with the Ministerial Board and stakeholders to ensure that these reforms are developed and taken forward effectively. We are also committed

to discussing the wider recommendations of the IAP, and working to achieve their implementation, where possible.

## Update on the work of the IAP

### Workstreams

- [Preventing the deaths of women in custody](#)

Following the self-inflicted deaths of 12 women 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.

The IAP received 45 detailed, well-evidenced responses from members of the Ministerial Board on Deaths in Custody, the Advisory Board on Female Offenders and IAP stakeholders with their views on how best to prevent suicide and self-harm and keeping women safe. At the same time the IAP sought the views of women in prison - in particular those acting as Samaritan Listeners, insiders and responsible peer mentors. In total, the IAP heard from over 60 women in custody.

There was a high degree of agreement across the information received by the IAP. Considering why there has been a sharp and sudden rise in women's deaths in custody, respondents gave five main reasons:

- A reduction in staffing levels combined with the loss of experienced, trusted staff, plus vacancies in mental health teams, and the accompanying reduction in activity, time out of cell and time to listen and talk;
- Unmet mental health, drug and alcohol treatment needs and the discernible increase in the vulnerability and complex needs of women received into prison;
- An increase in illicit drug use, intimidation, bullying and debt in custody;
- A marked decrease in use of release on temporary licence (ROTL), an increased likelihood of homelessness on release and high numbers of recalls;
- The knock on effect of the hasty closure of Holloway prison including increased distance from home and pressure on other establishments combined with the widespread closure of women-only support services in the community.

The IAP Chair presented the paper on the date of publication for discussion to the Advisory Board on Female Offenders (ABFO) chaired by Justice Minister Dr Phillip Lee MP.

The working paper, drawing together interim findings and recommendations, was published on 28 March to coincide with the Prison and Probation Ombudsman's [publication of lessons to be learned from their investigations into the individual deaths of nineteen vulnerable women in custody](#). It is intended that the impact of these two papers will lead to significant practice change in policing, prisons, health and housing services.

- Monitoring implementation of Harris Review recommendations

- Deaths from natural causes – The IAP hope to analyse deaths from natural causes in prisons, with a focus on avoidable deaths.
- Deprivation of Liberty Safeguards - IAP discussed with the CQC on 30 Jan the issue of (a) the increasing amount of DOLs and (b) the lack of oversight of such deaths following the proposed removal of them from inquests.
- Establish basis for IAP to act as national data source - The IAP intends to build up a library of research data to aid the synthesis and dissemination of learning:
  - International comparators - The IAP, in collaboration with ICPR at Birkbeck, Penal Reform International and the Winston Churchill Memorial Trust aims to collect international data to inform advice and research, and potentially compare with domestic data.
  - 2015 Statistical report - The IAP, in conjunction with the University of Durham, has published the IAP's 2015 annual statistical report on deaths in state custody.
- Thematic Review into Deaths of Detained Patients - The IAP, with the University of Warwick, will undertake analysis of clinical reviews of detained patient SIDs in 2014.
- The IAP is awaiting the publication of Dame Elish Angiolini's review into deaths and serious incidents in police custody, and stands ready to help with the sharing of learning and implementation of recommendations.

### **Evidence to review/enquiries**

- [Written](#) and [oral](#) submissions to Joint Committee on Human Rights
- Discussions with Cabinet Office re: Review of Expert Advice – Dec 2016
- Written evidence provided to Lord Farmer's inquiry on the importance of family contact for those in prison – Dec 2016

### **Stakeholder and public engagement**

- Partnership with Inside Time and Prison Radio
  - The IAP is working with [Inside Time](#) and Prison Radio, supported by the Samaritans, to directly ask prisoners for their views on how best to safeguard those in custody. The initiative was launched in the [February 2017 issue of Inside Time prisoners' newspaper](#) and calls for prisoners to give their insights and recommendations on preventing suicide and self-harm. Further articles have followed in subsequent issues thanking those who have written in and requesting further ideas. Their solutions will be presented to Ministers, operational leads and the Ministerial Board.
  - Emerging themes from the letter include: improving first night entry and induction, dealing with spice and debts, avoiding medication delays, mental health awareness training for staff, responding to the plight of IPP prisoners, the need for purposeful activity and family contact, dealing with threats of violence and intimidation, and the need for care and compassion.

- Institute regular learning days with bereaved families (with INQUEST) – spring/summer 2017

#### Meetings and visits include:

- Peter Clarke (HMIP) – 25 October 2016
- Chief Coroner [HHJ](#) Mark Lucraft [QC](#) – 15 November 2016
- John Howard Centre – 6 Dec 2016
- Luke Serjeant ([HMPPSNOMS](#)) – 4 Jan 2017
- Fiona Grossick (NHS England) – 5 Jan 2017
- Digby Griffith ([HMPPSNOMS](#)) – 9 Jan 2017
- Broadmoor hospital – 12 Jan 2017
- Police custody suite (Redhill) – 17 Jan 2017
- Phil Copple ([HMPPSNOMS](#)) – 19 Jan 2017
- HMP Foston Hall visit – 20 Jan 2017
- Faculty of Forensic and Legal Medicine – 30 Jan 2017
- CQC – 30 Jan 2017
- Women's Estate summit – 1 Feb 2017
- HMP Woodhill meeting – 1 Feb 2017
- SASH project update – 2 Feb 2017
- HMP Drake Hall visit – 6 Feb 2017
- Kate Davies [OBE](#) (NHS England) – 7 Feb 2017
- Equality & Human Rights Commission – 8 Feb 2017
- HMP Bronzefield visit – 14 Feb 2017
- Justin Russell (DG Prison Reform) – 27 Feb 2017
- Stephen Shaw – 20 March 2017

#### **Advice to Ministers**

- Meeting with Sam Gyimah MP – 24 October 2016
- Meeting with Dr Phillip Lee MP – 23 November 2016
- Meeting with Sam Gyimah MP – 20 February 2017
- Meeting with Nicola Blackwood – 1 March 2017
- Meeting with Sam Gyimah MP – 8 March 2017
- Visit to HMP Low Newton with Dr Lee MP – 9 March 2017
- Meeting with Dr Phillip Lee MP – 22 March 2017

## **IAP Learning Library**

The Secretariat acts as a resource for the sharing of learning and information about the means of preventing deaths in custody. In June 2011, the Secretariat launched the **IAP's Learning Library**, which contains learning documents from the criminal justice agencies and third sector organisations which may have cross sector applicability. We are constantly reviewing the content of the Learning Library and want to build this up as a useful national data source. If you think there are documents that should be included, please contact the Secretariat via [iapdeathsincustody@noms.gsi.gov.uk](mailto:iapdeathsincustody@noms.gsi.gov.uk)

# **NEWS**

## **ANNUAL REPORTS AND STATISTICS**

### **Safer in Custody Statistics – ~~December~~September 2016**

Safety in custody statistics cover deaths, self-harm and assaults in prison custody in England and Wales. This bulletin was published on ~~26~~ ~~January~~October 201~~7~~~~6~~, and includes statistics covering 12-month periods to end of ~~December~~ September 2016 for deaths in prison custody and 12-month periods to end of ~~October~~June 2016 for self-harm and assaults.

The full report and summary tables can be found at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/595797/safety-in-custody-quarterly-bulletin.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/595797/safety-in-custody-quarterly-bulletin.pdf) <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2016>

### **HMIP Annual Report 2015-16**

This is the first report from the new HM Chief Inspector of Prisons, Peter Clarke.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/571732/hmip-annual-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/571732/hmip-annual-report.pdf)

### **PPO Annual Report 2015-16**

This is the fifth annual report of the Prisons and Probation Ombudsman. Over the past year, deaths in custody have risen sharply, with a 34% rise in self-inflicted deaths, steadily rising numbers of deaths from natural causes. The number of complaints from prisoners also remains very high. The Ombudsman notes in his report: “It is deeply depressing that suicides in custody have again risen sharply but it is not easy to explain this rising toll of despair. Each death is the tragic culmination of an individual crisis for which there can be a myriad of triggers.”

The full report can be found here:

[http://www.ppo.gov.uk/wp-content/uploads/2016/09/PPO\\_Annual-Report-201516\\_WEB\\_Final.pdf](http://www.ppo.gov.uk/wp-content/uploads/2016/09/PPO_Annual-Report-201516_WEB_Final.pdf)

### **House of Commons, Justice Committee – Prison Safety, 6<sup>th</sup> report of session 2015/16**

This report examined the Government’s response to the deterioration in prison safety in England and Wales which began in 2012. Evidence was taken from the Prisons Minister and the Chief Executive of the National Offender Management Service on prison safety in December 2015, and statistics published in January and April 2016 showed higher rates of self-harm and assaults than in the previous 12 months, and significant growth in the number of incidents compared to the previous quarter. The committee wished to reflect on the progress made by the Ministry of Justice and ~~NOMS~~HMPPS in their efforts to stabilise the rise in assaults against prisoners and staff, incidents of self-harm and self-inflicted deaths, and obtained the views of several key stakeholders in writing.

The full report can be found here:

<http://www.publications.parliament.uk/pa/cm201516/cmselect/cmjust/625/625.pdf>

### **Bromley Briefings – Autumn 2016**



324 people died in prison in the year to September 2016, the highest number on record. A third of these deaths were self-inflicted. Serious assaults in prison have more than doubled in the last three years. Nearly half of the adult male prisons inspected in 2015–16 were judged to be failing on safety. Very few people will have missed the news coverage prompted by these appalling facts over the last year. It is to the new Secretary of State's credit both that she acknowledges her personal accountability for making prisons safe, and that she has found the money for an additional 2,500 prison officers to back that up. But there are statistics in this regular annual briefing which should cause alarm precisely because they are now so familiar. The UK continues to have the highest rate of imprisonment in western Europe. Sentence lengths in the Crown Court have risen by a scarcely believable 30% over ten years. In just two months in the autumn of this year, an unpredicted rise in the population swallowed up the equivalent of a new prison.

The full report can be found here:

<http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Autumn%202016%20Factfile.pdf>

### **Women in the criminal justice system annual statistics 2015/16**

This publication compiles statistics from data sources across the Criminal Justice System (CJS), to provide a combined perspective on the typical experiences of women who come into contact with it. It considers how these experiences have changed over time and how they contrast to the typical experiences of men. No causative links can be drawn from these summary statistics, and no controls have been applied to account for differences in circumstances between the males and females coming into contact with the CJS (e.g. average income or age); differences observed may indicate areas worth further investigation, but should not be taken as evidence of unequal treatment or as direct effects of sex.

The full report can be found here:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/572043/women-and-the-criminal-justice-system-statistics-2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/572043/women-and-the-criminal-justice-system-statistics-2015.pdf)

### **IAP End of Term Report August 2016**

This report covers the period since the last end of term report in April 2015 to August 2016. It has continued to be a period of flux; two new governments have led to changes in ministerial portfolios and priorities.

Overall, deaths in custody continue to be a source of wide concern, although the main increases are caused by the continuing rise in prison deaths. Deaths in other custodial locations have remained constant, or are decreasing in the case of those detained under the Mental Health Act.

The full report can be found here:

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2016/09/IAP-End-of-Term-Report-2016.pdf>

## **LEARNING**

**Equality and Human Rights Commission – Non-natural deaths following prison and police custody**

The deaths of people in the immediate aftermath of state detention have received considerably less attention than the deaths of those who die in custody. This research was commissioned by the Equality and Human Rights Commission (EHRC) in October 2015 with the aim of contributing to the understanding of the size and extent of the problem. In order to do this, the EHRC reviewed the existing literature and investigated relevant legal and policy frameworks. They then analysed a number of data sources including the National Offender Management Service, The Prison and Probation Ombudsman and the Independent Police Complaints IPCC. They were also able to carry out a few interviews/focus groups with a small selection of key stakeholders.

The full report can be found at:

<https://www.equalityhumanrights.com/sites/default/files/research-report-106-non-natural-deaths-following-prison-and-police-custody.pdf>

### **Charlie Taylor report – Review of the Youth Justice System**

In 2007, 225,000 children in England and Wales received a caution or conviction for a notifiable offence. Of these children, 106,000 were first-time entrants to the system having never before received a caution or conviction. 126,000 were prosecuted at court, and 5,800 were sentenced to custody. The average monthly under-18 custodial population for 2007 was 2,909. Since that high watermark the number of children dealt with by the youth justice system has reduced spectacularly, with consistent year-on-year falls. The number of children cautioned or convicted in 2015 was 47,000 – down 79% since 2007. Over the same period the number of children entering the youth justice system for the first time has fallen by 82%, the number prosecuted at court has reduced by 69%, and there are now around only 900 under-18s in custody.

To read the full report, please use this link:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/577103/youth-justice-review-final-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577103/youth-justice-review-final-report.pdf)

### **PPO – Learning Lessons Bulletin – Self-inflicted deaths among women prisoners**

Prompted by the recent rise in self-inflicted deaths of women in prison, the bulletin reviewed 19 cases between 2013 and 2016 where women took their own lives. This small sample cannot explain this rise, but does identify a number of important areas of learning, including: better assessment and management of risk, improving suicide and self-harm prevention procedures, addressing mental health issues, combating bullying and ensuring timely emergency responses.

The full report can be found here:

[http://www.ppo.gov.uk/wp-content/uploads/2017/03/PPO-Learning-Lessons-Bulletin\\_Self-inflicted-deaths-among-female-prisoners\\_WEB.pdf](http://www.ppo.gov.uk/wp-content/uploads/2017/03/PPO-Learning-Lessons-Bulletin_Self-inflicted-deaths-among-female-prisoners_WEB.pdf)

### **PPO – Learning Lessons Bulletin – Dementia**

In 2013, the National Offender Management Service issued a guide for prison officers, to help them understand dementia and deal more effectively with prisoners who are affected. This bulletin aims to identify some learning from our investigations into deaths of prisoners with dementia, in order to help Prison Service staff respond more effectively to this group of prisoners.

The full report can be found here:

[http://www.ppo.gov.uk/wp-content/uploads/2016/07/PPO-Learning-Lessons-Bulletins\\_fatal-incident-investigations\\_issue-11\\_Dementia\\_WEB\\_Final.pdf#view=FitH](http://www.ppo.gov.uk/wp-content/uploads/2016/07/PPO-Learning-Lessons-Bulletins_fatal-incident-investigations_issue-11_Dementia_WEB_Final.pdf#view=FitH)

### **PPO – Learning Lessons Bulletin – Homicides**

The PPO have published a learning lessons bulletin which examines the lessons to be learned from the Ombudsman's investigations into the killing of one prisoner by another. This is the second bulletin they have published on this topic. Homicides are, thankfully, still rare in English and Welsh prisons, although they have increased over recent years. The killing of one prisoner by another in a supposedly secure prison environment remains shocking, and it is essential to seek out any lessons that might prevent these occurrences in future.

The full report can be found here:

[http://www.ppo.gov.uk/wp-content/uploads/2016/09/PPO-Learning-Lessons-Bulletin\\_Homicides\\_issue-12\\_WEB.pdf#view=FitH](http://www.ppo.gov.uk/wp-content/uploads/2016/09/PPO-Learning-Lessons-Bulletin_Homicides_issue-12_WEB.pdf#view=FitH)

### **HMIP – Findings paper - Life in prison: Contact with families and friends**

This paper summarises the literature concerning the importance of prisoners maintaining relationships with the outside world and, in particular, with their family and friends. It draws on evidence from recent inspections of adult prisons undertaken by HM Inspectorate of Prisons and survey data from inspection reports published between 1 April 2015 and 31 March 2016. This paper provides an overview of the ways in which prisoners are able to keep in contact with their family and friends, and how they experience this.

The full report can be found here:

<http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/08/Contact-with-families-and-friends-findings-paper-2016.pdf>

### **CQC – Learning, Candour and Accountability**

This report describes what CQC found when it reviewed how NHS trusts identify, investigate and learn from the deaths of people under their care. It concludes that many carers and families do not experience the NHS as being open and transparent and that opportunities are missed to learn across the system from deaths that may have been prevented. Many of the NHS staff we heard from shared this view, together with a commitment for this to change.

The full report can be found here:

<http://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>

### **NICE guidelines**

NICE and the Department of Health are working together to develop a guideline on suicide prevention. It will be used to develop the NICE quality standard for suicide prevention and publication is anticipated for Sept 2018.

Link to the project outline and documents can be found at:

<https://www.nice.org.uk/guidance/indevelopment/gid-phg95>

### **Surrey Police guidelines**

This paper provides practical instruction and advice for officers on how to deal with incidents of serious illness, deliberate self-harm, deaths in or following custody and deaths following contact with police.

<https://www.surrey.police.uk/policies-and-procedures/deaths-or-serious-injury-dsi-in-custody-or-following-police-contact-procedure/>

### **Suicide in Prisons: Prisoners' Lives Matter: Graham J Towl, David A Crighton, Toby Harris**

"A superb publication and coming at exactly the right time... cuts through the rhetoric with a forensic analysis of the problems coupled with practical, low cost and rapidly achievable recommendations"- John Podmore, International Prisons Consultant and former prison Governor; "Rarely has a book been more timely or pertinent than this one... a thorough, wide-ranging and nuanced account... which contextualises, describes and analyses 36 years of data... a call to arms for those working in penal research, policy and practice"- Philippa Tomczak, University of Sheffield; "Places the issue firmly in the context of theoretical perspectives, recent research and expert commentaries... A book for practitioners, policy-makers, researchers and students alike"- Carol Robinson, University of York; "An important book about a subject that receives too little attention"- John Bateson, San Francisco, author and former suicide prevention counsellor; "Can be the starting point for changing opinions, policies, systems and lives for the better"- Elizabeth Scowcroft, Nottingham Trent University/The Samaritans; "Particularly valuable for students interested in this important topic"- Dominic Aitken, Oxford University.

The book can be found here:

<https://www.amazon.com/Suicide-Prisons-Prisoners-Lives-Matter/dp/190997644X>

### **IPCC learning lessons bulletin 29**

This bulletin sets out learning from cases covering a range of issues. These include self-harm, sudden illness and hidden injury within the custody setting. In particular, the supply of relevant information to custodial providers, adequate risk assessment and appropriate rousing.

The full report can be found here:

[https://www.ipcc.gov.uk/sites/default/files/Documents/learning-the-lessons/29/LearningtheLessons Bulletin29 March2017.pdf](https://www.ipcc.gov.uk/sites/default/files/Documents/learning-the-lessons/29/LearningtheLessons%20Bulletin29%20March2017.pdf)

### **Howard League for Penal Reform: Preventing prison suicide – staff perspectives**

Centre for Mental Health and the Howard League for Penal Reform are working together to investigate suicide prevention in prisons. The work explores how police, the judiciary, prisons and health care providers can collaborate to prevent people from losing their lives through suicide in prison. This is the fourth in a series of briefings. Centre for Mental Health's earlier briefing presented perspectives of people in or with previous experience of prison (Centre for Mental Health and Howard

League, 2016). This briefing discusses the perspectives of staff working in prison as well as those reviewing clinical care post suicide.

The full publication can be accessed at: [Howard League Preventing prison suicide.- Staff perspectives](#)

## **RECENT MEETINGS**

### **Panel Meeting – June 2016**

The panel met on 8 June 2016 and it was Kate Lampard's final meeting as temporary chair. The panel were updated on the recruitment of a new chair of the IAP and the review of the IAP that Kate had undertaken during her tenure. Other items discussed included remote vital signs monitoring, panel membership recruitment, quarterly statistics of deaths in custody and the Home Office review of deaths and serious incidents in police custody being led by Dame Elish Angiolini.

*Copy of the full minutes can be found on the IAP website:*

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2016/10/Minutes-of-IAP-meeting-8-June-2016.pdf>

### **Ministerial Board Meeting – June 2016**

The Ministerial Board met on 28 June 2016 and was hosted at the Department for Health with Andrew Selous MP (Minister for Prisons and Probation) chairing the meeting. The Board heard from Kate Lampard about the review that she had completed regarding her review of the Ministerial Council. Juliet Lyon's appointment as new Chair of the IAP was welcomed. Nigel Newcomen CBE, Prison and Probation Ombudsman, spoke about two recent reports that had been published on early days in custody and prisoner mental health, and the Howard League introduced a report that had been published in May 2016: Preventing Prison Suicide.

*Copy of the full minutes can be found on the IAP website:*

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2016/11/Minutes-of-MBDC-meeting-28-June-2016.pdf>

### **Panel Meeting – October 2016**

The IAP met on 18 October 2016. This was the first meeting chaired by Juliet Lyon since her appointment as Chair of the panel. The panel were updated on recent discussions with Department of Health, Home Office and ~~NOMSHMPPS~~ regarding potential areas of work that the panel could be involved in. Staff from ~~NOMSHMPPS~~ presented an update on the Suicide and Self-Harm project currently underway in the prison estate.

*Copy of the full minutes can be found on the IAP website:*

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2017/01/IAP-Minutes-of-meeting-18-October-2016.pdf>

### **Ministerial Board Meeting – November 2016**

The twenty-third Ministerial Board met on 8 November 2016 and was hosted at the Home Office with Rt Hon Brandon Lewis MP, Minister for Policing and the Fire Service, in the Chair. Sam Gyimah, the Prisons and Probation Minister at MOJ and Nicola Blackwood, Public Health and Innovation Minister at Department of Health, were also in attendance. As well as updates from the custodial sectors, the main focus of the meeting was hearing from Lord Harris on the Harris Review and discussing the Government response to its recommendations – including the recent announcements in the White Paper. The Board also heard from the MOJ Legal Team about funding for families for legal representation at inquests; the Department of Health discussed the forthcoming updated National Suicide Prevention Strategy,

and the Prison and Probation Ombudsman gave a summary of his latest learning lessons bulletins on dementia-related deaths and homicides.

*A copy of the minutes will be uploaded to the IAP website after they have been endorsed at the next meeting in June 2017.*

### **Panel Meeting – December 2016**

The panel met on 7 December 2016. They heard an update on the Suicide and Self-Harm Project and the recent review on the care and management of transgender offenders. Panel members also discussed the IAP 2015 statistical report, due to be published soon, recruitment of new panel members and IAP priorities for the current year.

*Full copy of the minutes can be found here:*

<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2017/02/Minutes-of-IAP-meeting-7-December-2016.pdf>

### **Panel Meeting – February 2017**

This meeting was focussed largely on discussion of, and taking forward the panel's workstreams, in particular the evidence collation on deaths of women in prison, the collaboration with Inside Time and the IAP annual statistical report.

*A copy of the minutes will be uploaded to the IAP website after they have been agreed at the next meeting in May 2017.*

## **Practitioner and stakeholder group**

There are currently over 150 members of the practitioner and stakeholder group, drawn from inspectorate and investigative bodies, lawyers, third sector organisations, families, academics and practitioners from the custodial sectors. The Panel would like to encourage practitioners from a range of organisations, particularly mental health settings, as well as families to join the group.

As a member of the group you can expect to receive regular communication with links to relevant news and publications from across the sectors; updates from the IAP website and invitations to stakeholder events.

If you would like to join the practitioner and stakeholder group please contact the Secretariat at [iapdeathsincustody@noms.gsi.gov.uk](mailto:iapdeathsincustody@noms.gsi.gov.uk).

## **Recruitment of new IAP members**

The tenures of the existing panel members (other than the Chair) are coming to an end. The Government has therefore recently started a recruitment campaign for up to four new panel members. We would encourage those who feel they meet the criteria to apply for this important role. Applicants would need to commit three days a month for an annual honorarium of £10,000. Full details, once published, can be found on the Cabinet Office public appointments page:

<https://publicappointments.cabinetoffice.gov.uk/>

We will publish a direct link to the recruitment campaign once it goes live.



# **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 since 2014.

### **Matilda MacAttram**

~~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 has been a member of the Independent Advisory Panel on Deaths in Custody 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 Independent Advisory Panel on Deaths in Custody since 2014.

### **Dr Meng Aw-Yong**

Dr 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 Independent Advisory Panel on Deaths in Custody since 2014.

### **Prof Graham Towl**

Professor 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 Independent Advisory Panel on Deaths in Custody since 2014.

## **The Secretariat**

The Secretariat acts as support to the Independent Advisory Panel and the Ministerial Board on Deaths in Custody. They are:

Andrew Fraser - Head of Secretariat  
Kish Hyde - Deputy Head of Secretariat  
Angie Hinksman - Secretariat Support