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

Independent Advisory Panel on Deaths in Custody

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Dear Minister Caulfield,

I am writing on behalf of the Independent Advisory Panel on Deaths in Custody to outline our key areas of focus regarding patient safety and access to care, treatment, and support for offenders in custody and the community. The issues I have set out below cut across government departments and agencies and require strategic join-up and leadership to significantly reduce – and ultimately prevent – the worryingly high number and rate of deaths in custody. We understand and support your significant leadership role in achieving this as Mental Health Minister. The upcoming meeting of the Ministerial Board on Deaths in Custody (MBDC) on 13 May will provide a vital opportunity to discuss these issues further.

Greater transparency and independent scrutiny of deaths

The latest data show that 264 people died under the Mental Health Act (MHA) in 2022/23, with the numbers of those who died by suicide and 'natural causes' remaining concerningly high. The ethnicity of one in six patients who died was recorded as 'unknown', highlighting long-standing issues relating to data collection and publication.[1] As we have raised repeatedly over the last few years, the absence of high-quality and disaggregated data means it is much harder to understand inequities and prevent deaths across different population groups.

As you know, a key recommendation made by the Rapid Review into mental health inpatient safety was to improve the timeliness, quality, and availability of data which is currently

[1] CQC, 'Monitoring the Mental Health Act in 2022/23', 21 March 2024, available here.

"fragmented".[2] We welcome your commitment to bringing together stakeholders to identify improvements in this area and I am pleased to support this work through the Implementation Steering Group.[3] Poor data has been an issue for too long and impacts patient safety. Meaningful improvements to data capture must be delivered quickly and effectively.

However, better sources of data cannot alone improve patient safety. Our analyses show that people detained under the MHA have the highest mortality rate across all places of custody, with our latest analysis – due to be published in the coming weeks – showing the rate as three times higher than prisons. I have enclosed a confidential copy of the report. Yet, despite this alarmingly high mortality rate, there remains a troubling deficit in independent investigations into these deaths prior to inquests.

An independent body tasked with investigating deaths under the MHA is vital for ensuring that these deaths are explored with rigour and consistency. It will help better understand why the mortality rate appears disproportionately high, and thereby ensure that learning can be identified and embedded. This is an area we are considering carefully as we look to make recommendations over the next year, and we hope to work with you and your officials as we take it forward.

Mental health transfer of prisoners

We were deeply concerned by the findings of two reports published earlier this year which highlighted the chronic lack of appropriate mental health inpatient beds across the country. A report by the Chief Inspector of Prisons found that severely mentally unwell individuals *"linger in prison for weeks, often months and even, in the worst cases, for more than a year waiting for their transfer to be completed"*.[4] Worryingly, of the 185 patient cases looked at across 21 prisons, fewer than 15% of patients were transferred within the 28-day target.

Further, a report by the Independent Monitoring Board found an overreliance on the use of care and separation units to manage the needs of prisoners with mental ill health due to a lack of alternative provision in the community. The report also questioned the prolonged use of segregation of prisoners serving a sentence of Imprisonment for Public Protection (IPP),[5] amidst a concerning and sharp increase in self-inflicted deaths among IPP prisoners.[6] I welcomed your interest in this issue at a recent meeting of the MBDC.

Prisons are not suitable or safe environments for people experiencing severe mental illness and heightens their risk of self-harm and/or suicide. Continued delays to transfers are also likely to impact on the safety and wellbeing of prison staff who, despite their best efforts, do not have the skills, resources, or training to safely manage the needs of prisoners with complex and often comorbid diagnoses. With the draft Mental Health Bill not being progressed in this Parliament, we are concerned that a lack of statutory requirement will mean that the 28-

[2] DHSC, 'Rapid review into data on mental health inpatient settings: final report and recommendations', 28 June 2023, available here.
[3] DHSC, Government response to the rapid review into data on mental health inpatient settings', 21 March 2024, available here.
[4] HMIP, 'A thematic review of delays in the transfer of mentally unwell prisoners', February 2024, available here.
[5] IMB, 'Segregation of men with mental health needs: A thematic monitoring report', January 2023, available here.
[6] MoJ & HMPPS, 'Deaths in prison custody 1978 to 2023', 25 January 2024, available here.

day target will continue to be routinely unmet, with prisoners currently waiting an average of 85 days to be sent to hospital.[7]

The current lack of available data showing the number of prisoners awaiting assessment under the MHA, awaiting a bed following assessment, and the time awaited prevents benchmarking and informed discussion. I would be grateful to know what steps your department is taking to speed up mental health transfers and access to treatment in the absence of the statutory time limit proposed in the draft Mental Health Bill.

Access to community mental health provision

We welcomed the presumption against sentences of 12 months or less introduced in the Sentencing Bill by the Ministry of Justice (MoJ). This is an important step towards reducing the considerable demand that short sentences and overcrowding are placing on prison mental health, primary care, and substance misuse teams trying to deliver their services in the context of serious and enduring capacity challenges across the prison estate. The success of this measure – which is estimated to increase probation caseload by between 1,700 and 6,800 by the end of 2024/25[8] – will be dependent upon a holistic and joined-up approach between justice and health agencies.

Despite CSTRs being introduced over 20 years ago, it is our view that current arrangements for treatment requirements – including the willingness and ability of community services to accept and treat offenders – are inadequate, with significant geographical inequalities in availability. As the Justice and Home Affairs Committee recently found, *"the need for mental health, and alcohol and drug treatment far exceeds the current rate of imposition of [CSTRs], which itself exceeds the availability of treatment".*[9] I would be grateful to know what steps your department is taking, in partnership with NHS England, the MoJ, and HM Prison and Probation Service, to ensure CSTRs are working effectively, and treatment services are adequately planned, structured, and resourced to meet the expected increase in demand.

As you know, the Panel provides independent advice and expertise to prevent deaths in custody. We recognise the steps being taken by you and your colleagues across government to address significant challenges facing custody and community health and justice services and want to express our ongoing wish to support these efforts. I look forward to hearing back from you.

Yours sincerely,

Lynn Emslie, Chair of the Independent Advisory Panel on Deaths in Custody
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[7] HMIP, 'A thematic review of delays in the transfer of mentally unwell prisoners', February 2024, available here.
[8] MoJ, 'Sentencing Bill – Changes on the presumption of the suspension of short sentences', 14 November 2023, available here.