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

Independent Advisory Panel on Deaths in Custody

Chair: Lynn Emslie
102 Petty France
7th floor
London, SW1H 9AJ
www.iapondeathsincustody.org

16 July 2024

Dear Baroness Merron,

I am writing on behalf of the Independent Advisory Panel on Deaths in Custody (IAPDC) to congratulate you on your recent appointment as the Minister for Mental Health. We wholly welcome your commitment to modernisation of the Mental Health Act 1983 (MHA) and addressing issues of disproportionality among individuals detained under the MHA and look forward to working with you.

Your appointment comes at a time of significant challenges, including persistent systemic failures which have led to a number of high-profile deaths in mental health in-patient units over the past few years. These challenges, although significant, provide a real opportunity for change and improved outcomes for individuals in in-patient mental health services.

The IAPDC is an advisory non-departmental public body, co-sponsored by the Ministry of Justice, Home Office, and Department for Health and Social Care (DHSC) with the aim of preventing deaths – both natural and self-inflicted – in all forms of custody. Our remit across all custody areas – prisons, police custody, immigration detention, and detention under the MHA – provides us with a unique role in facilitating learning and collaboration across the custodial landscape. We hope to work closely with you and your officials as your primary source of independent advice and expertise on preventing custody deaths.

Our latest statistical analysis of deaths in detention shows that patients detained under the MHA have the highest rate of death in all detention settings, including three times higher than that of prisons.[1] Despite this troublingly high death rate, a lack of high-quality data makes it difficult to gain a full understanding of these deaths to help inform effective policies and interventions, as highlighted by the findings of the rapid review into data on mental health inpatient settings commissioned by DHSC last year.[2] We will continue to support progress on the recommendations from the review, including through our participation in the Mortality Data Working Group, to ensure momentum is maintained and reform is achieved.

---

[1] IAPDC, 'Statistical analysis of recorded deaths in custody between 2017 and 2021', April 2024, available here.
[2] Department of Health and Social Care, 'Rapid review into data on mental health inpatient settings: final report and recommendations', March 2024. Please see relevant recommendation 4, available here.

Further, there is currently no process for independent investigations following a death in MHA detention. This creates serious discrepancies in the investigation of deaths compared to those in other detention settings which are independently investigated by the Prisons and Probation Ombudsman and the Independent Office for Police Conduct. This lack of independent scrutiny makes it difficult to identify and implement learning to prevent future deaths. We are currently exploring this issue and drawing up proposals for an independent investigatory function which we look forward to presenting to you and your officials over the coming year.

Wider reforms to the now 40-years-old MHA are desperately needed. In the context of the current prison capacity crisis, it is more vital than ever to ensure that prisoners with mental ill-health receive timely and appropriate care and support. There remain serious concerns around the significant delays in the transfer of acutely mentally unwell prisoners to secure mental health settings and the wholly inappropriate use of prisons and police custody as places of safety. We therefore hope to see the long-awaited reforms to the MHA included in the upcoming King's Speech, or otherwise introduced at the earliest possible opportunity.

Of further concern is the implementation of the Right Care, Right Person (RCRP) model under the National Partnership Agreement between the Home Office, DHSC, and partner organisations. While we welcome the guiding principles of the agreement – that individuals experiencing mental health crises should receive the right care from the right agency – concerns have been raised about the efficacy of partnership working between policing and health services. Effective commissioning of mental health services in the community is crucial to support the effective working of RCRP and ensure individuals at serious risk of harm to themselves and others are not left without appropriate support.

Fully joined up planning is also required for the effective delivery of community sentences and resettlement following release from custody. Community mental health services must be able to meet the increased demand for Mental Health Treatment Requirements resulting from efforts to relieve the prison capacity crisis and reduce risk to those in custody.

The Ministerial Board on Deaths in Custody (MBDC) plays a critical role in driving a strategic focus on wide-ranging issues across the custodial landscape. It acts as an important mechanism through which Ministers receive expertise and advice, including that of the Panel. However, we have previously had concerns about ministerial engagement with the MBDC. We would welcome your strong leadership at the MBDC to help drive forward progress on safeguarding the lives of individuals in state custody.

These challenges present an opportunity for reform and positive change to ensure crucial lessons can be learned to help safeguard the lives of those in places of detention. The Panel and I would welcome the opportunity to meet with you over the coming weeks to discuss how we can support the efforts of you and your officials to address these systemic issues.

Yours sincerely,

Lynn Emslie, Chair of the Independent Advisory Panel on Deaths in Custody
e: lynn.emslie@justice.gov.uk