Independent Advisory Panel on Deaths in Custody

# Autumn Newsletter

A Bird Doing Bird, HM Prison The Mount, Arts Society Rickmansworth Highly Commended Award for Drawing, Koestler Arts

September 2024

## Chair's Foreword

Welcome to the autumn edition of the IAPDC Newsletter. I would like to begin by thanking my former Panel colleagues Raj Desai and Pauline McCabe OBE, who recently stepped down, for their excellent work and commitment to reducing deaths in custody during their time on the Panel. They have left a lasting legacy with the workstream projects they have driven forward, and I wish them both the best for the future.

Together with my Panel colleagues Dr Jake Hard and Professor Seena Fazel, while we await new members, we will drive forward our 2024/25 workplan which we continue to make progress on. Our main priorities remain collecting evidence and addressing emerging issues strategically, sharing and embedding cross-custody insights, and concentrating on groups who are at heightened risk.

Following the General Election in July and the introduction of new co-sponsor Ministers, we have been working to build relationships with them as early as possible. The prison estate continues to dominate headlines with the significant capacity challenges it faces, which have a huge impact on the safety and well-being of people in prison. We have been vocal about the need for a long-term strategy to prevent this situation from happening again: the prison service needs to deliver the healthcare, support, and meaningful regime that is fundamental to keeping people in prison safe. In our early engagement with the new Prisons Minister, Lord Timpson, we continue to call for the establishment of non-negotiable policy 'redlines' that ensure custody numbers will never be permitted to exceed safe capacity.

Our commitment to reducing deaths among individuals in prisons, police custody, immigration detention, and Mental Health Act (MHA) detention remains strong. We have been collaborating with Ministers, officials, and key stakeholders to utilise their expertise and create safer custodial environments.

**Finally, I am keen to hear from you on your experience and expertise on how best to keep people safe in custody. You can contact us at iap@justice.gov.uk**

**Lynn Emslie**
IAPDC Chair

Independent Advisory Panel on Deaths in Custody

## Latest published deaths in custody statistics

### 308 deaths in prisons

In the 12 months to June 2024, there were 308 deaths in prison custody, a decrease of 2% from 313 deaths in the previous 12 months. Of these, 85 deaths were self-inflicted, a decreased of 8% from the 91 self-inflicted deaths in the previous 12 months.
Source: HMPPS and MoJ safety in custody statistics

### 23 deaths in police custody

In 2022/23, 23 people died in or following police custody, an increase of 12 compared to 2021/22. There were 52 apparent suicides within the first 48 hours after release from police custody, a decrease of five compared to 2021/22.
Source: IOPC deaths during or following police contact

### 2 deaths in immigration detention

In 2023, there were two deaths of people detained under Immigration Act Powers.
Source: Home Office immigration system statistics

### 264 deaths in MHA detention

The CQC were notified that 264 people died while detained under the MHA between April 2022 and March 2023. This is a fall on 270 deaths in the previous 12-month period.
Source: CQC monitoring the Mental Health Act

### 14 deaths in Approved Premises

There were 14 deaths of offenders residing in Approved Premises in 2022/23, an increase of one since 2021/22. Deaths in Approved Premises accounted for 1% of all deaths of offenders in the community in 2022/23.
Source: MoJ deaths of offenders in the community

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## Our priorities for prevention of deaths

We are making progress on our 2024/24 workplan, which you can find here.

***Putting the investigations of deaths under the MHA on an independent footing***

One of our key priorities is to improve investigations of deaths in MHA detention. Our latest statistical analysis of deaths in custody found that patients detained under the MHA have the highest rate of deaths in all custodial settings. However, unlike those in other settings, the deaths of patients detained under the MHA are not subject to independent investigations prior to a coroner's inquest. As a result, too often families bereaved by deaths in MHA detention feel they are left without answers and that opportunities to learn from deaths are missed.

We have been gathering evidence and speaking to key stakeholders to develop our recommendations for independent investigations into MHA-related deaths. Through our consultation so far, we have been seeking to understand the scope for either a new independent body to investigate these deaths, or for an existing independent investigative body to take on this role. We are in the process of drafting a report outlining our recommendations and highlighting the urgent need for independent investigations into deaths under the MHA, which we hope to publish later this year.

***Provide advice and support to help improve data, risk assessment processes, and support for vulnerable individuals to prevent suicides following police custody.***

Following our joint roundtable event with the National Police Chiefs' Council (NPCC) on preventing suicide following police custody earlier this year, we recently hosted our first Working Group with the NPCC, College of Policing (CoP) and representatives from policing, health and third sector organisations.

The Working Group aims to implement the recommendations from the roundtable and our 2022 report on preventing deaths at the point of arrest, during and after police custody by developing good practice guidance for inclusion in the current CoP authorised professional practice (APP) on 'Detention and Custody'. Discussions focused on reviewing, refining, and agreeing on good practice recommendations based on the best available evidence. We also discussed how to support police forces in conducting thorough pre-release risk assessments and collaborating with partners to provide multiagency support for vulnerable individuals being released from custody.

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## Recent Publications: MHA Risk Factors Report

Our latest report identifies the risk factors associated with premature mortality – and particularly suicide – among patients detained under the MHA. We carried out a scoping review of existing research in this area and found several potential risk factors, which are categorised below:

- **Sociodemographic** – male, older age, and being unemployed prior to being detained.
- **Clinical** – a prior suicide attempt.
- **Patient history** – mood disorders, substance misuse, and history of aggression.
- **Institutional** – length of stay, involuntary admission, and a lack of access to appropriate care.

Our research concludes that preventative interventions targeting specific risk groups and conditions could reduce premature deaths among detained patients. These interventions might include suicide prevention initiatives, evidence-based treatments for psychiatric and substance use disorders, and therapies to promote overall well-being in detention settings.

IAPDC member Professor Seena Fazel, who led on this research with his colleague Dr Amir Sariaslan, said:

***"Our research shows that patients detained under the Mental Health Act have a disproportionately high death rate. This review identifies a number of risk factors which contribute to premature mortality among these patients, most notably a previous suicide attempt. Other factors include diagnosis of mood disorders, substance misuse, and a history of aggression. While this is an important step in understanding these deaths, more research is needed in this area to ensure evidence is fully embedded in approaches to improve patient safety."***

You can read the report here.

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## Recent Publications: APCC Guidance

In June 2024, the Association of Police and Crime Commissioners (APCC) released guidance on preventing deaths in police custody  to aid police and crime commissioners' (PCCs) oversight of police forces. It offers examples of best practices and recommendations to prevent tragic losses of life at the point of arrest, while in custody or shortly after release.

The guidance draws on findings and recommendations from our 2022 report on avoidable police deaths, which you can access here. We collaborated with the APCC to ensure the guidance acknowledges and addresses the vulnerabilities of those interacting with the criminal justice system.

The APCC's guidance represents a crucial advancement in our joint efforts to prevent deaths at the point of arrest, during custody, and following release. Recent data underscores the importance of this work: in 2022/23, there were 23 deaths in custody, which is more than double compared to the previous year. Equally troubling is the consistently high number of deaths following release from custody, often without equivalent attention or scrutiny. In 2022/23, 52 individuals died by suicide within the first 48 hours after release, equating to one suicide per week.

PCCs play a critical role in shaping priorities, coordinating relevant services, and, given that all forces are operationally independent, promoting the sharing of best practices across regions. They also hold significant oversight and scrutiny responsibilities, which are essential for fostering a 'zero-tolerance' stance toward police custody deaths, as highlighted in Dame Elish Angiolini KC's landmark review into such incidents.

We are grateful to PCC Emily Spurrell during her time as APCC custody lead and her team for leading on this vital work and building on the recommendations from the Panel's report on avoidable deaths. We will continue to work closely with the APCC to advance these initiatives.

You can access the APCC's guidance here.

Umbrellas, Ann House (low secure mental health unit) Koestler Arts

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## What's next?

Following the appointment of the new departmental Ministers – Lord James Timpson OBE for Prisons, Baroness Gillian Merron for MHA detention, Dame Diana Johnson for police custody, and Dame Angela Eagle for immigration detention – we wrote to each of them outlining our main concerns and top priorities for their custody area. Some of these Ministers also have key role as co-chairs of the MBDC and we are looking forward to working with them to bring about a continuing and sustained reduction in the number of deaths in all forms of state custody.

We recently met with Lord Timpson, the Minister of State for Prisons, Probation and Reducing Reoffending where we discussed concerns about prison capacity and long-term plans to manage the prison population safely. We hope to meet with the other Ministers in the coming months and we will discuss the critical need for comprehensive strategies that encompass preventive measures, appropriate safeguarding measures, and robust oversight mechanisms.

The upcoming Ministerial Board on Deaths in Custody (MBDC) is scheduled for November this year. This will be the first MBDC since the General Election, and we are looking forward to engaging with the new Ministerial co-chairs, department co-sponsors and member organisations, to discuss and advance the Board's priority areas for 2024/25. The minutes from the last meeting of the Board in May 2024 can be found here.

Another priority for the remainder of the year is to fill current vacancies in the Panel to assist with progressing our workplan. We are looking forward to welcoming new members who will bring fresh perspectives and invaluable expertise to our work.

# Media appearances

*Keeping Safe*

## Receiving the right care in the right place at the right time



*Lynn Emslie*

Everyone deserves consistent, high-quality care and support - and that is no less true for people in prison. But people in prison are too often facing long delays to receiving the mental health care and treatment they need. A report published earlier this year by the Chief Inspector of Prisons found that unwell men and women "linger" in prisons for weeks, often months, and sometimes over a year whilst they wait to be transferred to a mental health hospital. These delays are unacceptable and are symptomatic of a long-term shortage of appropriate mental health beds across the country.



*Everyone deserves consistent, high-quality care and support*

Photo by Andy Aitchison

For people with mental health disorders, prompt access to appropriate treatments in the most suitable settings is essential for reducing the risk of complications and avoiding deterioration, which if left unaddressed may contribute to a more complex clinical and personal recovery for the individual. Fundamentally, we know that prisons are not suitable or safe environments for people with severe mental health illnesses. The added pressure of the high levels of turnover, overcrowding, and staffing challenges across the prison estate has meant that prison mental health services are under critical strain and can at times struggle to meet the increased demand.

I recently wrote to the Minister for Prisons and the Minister for Mental Health to raise these concerns on behalf of the Independent Advisory Panel on Deaths in Custody (IAPDC). As you may know, a legal 28-day limit to complete transfers from prisons to hospital was introduced in the draft Mental Health Bill. However, the Bill has been stalled since 2022 - and the IAPDC, along with prison and mental health charities, have expressed deep frustration over the lack of progress. I have set out to Ministers that the 28-day limit must be achieved in practice, with or without a new law. Key to ensuring this happens is a significant investment in additional mental health beds and skilled staff across the country.

I also know from my conversations with prison and healthcare staff that remittals - i.e., return to prison from a mental health hospital - can sometimes lead to a disruption in care. Section 117 of the Mental Health Act provides some patients detained in hospital with aftercare when they leave. However, research by the University of Manchester in 2020 found that only a minority (18%) of those remitted back to prison with a legal right to an aftercare plan had one in place at the point of follow-up. The research concluded that the benefits of receiving care in a mental health hospital "may have been lost on return to prison" because of "a lack of targeted aftercare". It is therefore vital to make sure that proper discharge and follow-up care arrangements are in place to reduce the risk of deterioration and hospital readmission.

I continue to visit prisons in England and Wales to better understand the challenges and opportunities - to keeping people in prison safe. Earlier this year, I visited HMP Cardiff with IAPDC member Dr Jake Hard. I also visited women's prison HMP Styal to learn about their individualised and psychologically informed care and support services. As ever, I want to hear from you about your experiences, ideas, and recommendations on how to keep people in prison safe. Write to me at: Freepost IAPDC, 102 Petty France, London - no stamp or anything else on the envelope is needed. I look forward to hearing from you.

*Lynn Emslie is Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC)*

Inside Time, June 2024

*Keeping Safe*

## New Prisons Minister brings opportunities for change



*Lynn Emslie*

Following last month's general election and change in government, James Timpson OBE has been appointed as the new Minister for Prisons, Parole and Probation. My Panel colleagues and I congratulate Minister Timpson on his appointment and wholly welcome his commitment to prison reform and helping ex-offenders reintegrate into society. While this is a time of significant challenges across the prison estate, I believe there are real opportunities to drive long-term change for prisons and people in prison.

As you know all too well, however, prisons are dangerously overcrowded, and the prison service is in crisis. The rapidly increasing prison population has meant that too many prisons are struggling to even deliver the basics. Prison overcrowding affects your access to education and work activities, healthcare services including mental health, addiction, and other rehabilitative programmes, and contact with your loved ones, key workers and other areas of support. I know from many of you that these activities and services play a central role in keeping everyone safe.

I have written to Minister Timpson making it clear that tackling the current prison overcrowding and avoiding future overcrowding is the number one priority. Our advice to the Minister is that a policy decision-making red line must be introduced to make sure that prison numbers cannot increase beyond the ability of the prison service to safely manage individuals under its care. This must include a commitment that before prison numbers are increased, the risks to the safety of people in prison and staff have been identified and measures introduced to reduce those risks. My Panel and I firmly believe that a longer-term strategy and step change in policy-making processes is urgently needed to make sure that the prison service is never in this position again. Therefore, we welcome the government's recently announced plans for a 10-year capacity strategy which we believe must include these non-negotiable 'red lines'.

> *"a policy decision-making red line must be introduced to make sure that prison numbers cannot increase beyond the ability of the prison service to safely manage individuals under its care"*

As well as this, we will continue to advise the new government on the wider changes that are desperately needed. This includes the better use of community sentencing and reviewing the current sentencing policy, which is filling prisons beyond safe capacity. In line with this, we welcome the recent decision by the government to recruit an additional 1,000 probation officers to support the release of offenders, which is especially important given the new plans to release prisoners at an earlier point in their sentence. We also believe it is important that before the prison estate expands with new prison builds, HMPPS must get the basics right by having the right number of prison officers, healthcare and other staff members to deliver a safe, decent and rehabilitative environment. Without this, prisons cannot consistently provide purposeful and rehabilitative regimes, and deliver services to improve the health and wellbeing of people in prison.

I really value reading the letters you send me and hearing about your experiences and perspectives. I will continue to engage with Minister Timpson as well as senior leaders at HMPPS and the Ministry of Justice, and I am keen to share your thoughts and experiences with them. So please do share these by writing to us at Freepost IAP. I am particularly interested in hearing about your opinions on how the new government can make long-term sustainable change. I am also interested in your perspective on the recently announced early release plans and what you think a successful early release needs to include? I look forward to hearing from you.

*Lynn Emslie is Chair of the Independent Advisory Panel on Deaths in Custody (IAPDC)*

Inside Time, August 2024

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