Independent Advisory Panel on Deaths in Custody

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Minutes of IAPDC meeting: 4 March 2025

Attendees:
Lynn Emslie - Chair
Kate Eves
Jake Hard
Andrew Harris
Liz Jessop, Dash Review – for item 4
Georgia Richards – for item 5

Apologies:
Seena Fazel

Declaration of interests

1. No declarations of interest were reported.

Item 1: Minutes and actions from last meeting

2. Kate stated that she will share a small amendment to the January Panel meeting minutes. All other Panel members had provided edits to the minutes.
3. All actions were complete or in progress.

Action 1: Kate to share amendment to January Panel meeting minutes *(complete).*

Item 2: IAPDC Workplan 2025-26

4. Mental Health Act (MHA) detention: the intention was for the Panel to present their paper on MHA investigations to the next Ministerial Board on Deaths in Custody (MBDC). The Panel needed to agree on the next tranche of stakeholders to engage with before then. The item will be taken forward into the new workplan.
5. The Secretariat asked Panel members to consider the sequencing and interaction between the Panel and the MBDC's workplans as the Panel is also driving forward some work items on the Board's workplan. Lynn mentioned that she has been discussing data with health co-sponsors, that information sharing is

a key theme across many different strands of work and that work on ligature points pertains to all the custodial sectors.

6. Prisons: the Panel discussed the possibility of focussing on mental health screening and transfers from prison to hospital. Jake stated that the Panel do not know if there is a higher rate of deaths among those awaiting transfer and would be keen to understand how long people wait. Andrew suggested a focus on data at an earlier stage in the transfer process to help determine what the Panel should focus on going forward. Lynn suggested a summary of the current position from different perspectives, such as prison governors and HM Inspectorate of Prisons as well as the Panel, which could be used as a baseline which sectors may find useful. As time progresses, work with NHS England might be helpful to draw out people's access to mental health services in prison and how they are managed.
7. Jake stated that it would be helpful to obtain data on numbers of self-inflicted deaths and self-harm among people awaiting MHA transfer to help to build a picture of this particular group's needs and the delay of transfer being a risk. Kate suggested exploring whether placing this group on ACCT is a form of safeguarding and if it helps. This could apply to other actions taken by prisons, such as family engagement.

Action 2: Secretariat to ask HMPPS for data on numbers of self-inflicted deaths and self-harm for people awaiting transfer.

8. Reducing deaths by ligature points: Jake has met with colleagues from the Scottish Prison Service who are happy to contribute to the MBDC policy forum. It was noted that this item on the current workplan will need to be amended to reflect new work on the paper and the policy forum.
9. Addressing safety risks in the women's estate: this item is closed pending the outcome of the review of the women's estate. The Chief Medical Officer's report may also have recommendations which can be explored.
10. Learning the lessons from COVID-19 in prisons: no further work is envisaged so the item is closed.
11. Addressing safety risks associated with IPP prisoners: Lynn continues to attend the Prison Service working group but there is no direct work the Panel can feed into. The Panel will maintain a watching brief.
12. Post police-custody suicides: Andrew fed back on the NPCC meeting on risk assessment and management. The main focus was the need for a consistent process to be followed across the country, and he noted a big gap between policy and practice, for instance, despite the APP guidance stating all children must have a risk assessment, not all of them do.
13. Disproportionality and use of force: currently there is a paucity of information. Panel members discussed looking at disproportionality of the use of force, regardless of who it is used on, use of Appropriate Adults, callouts for firearm police officers when a suspect is from ethnic minority or experiencing mental health crisis, Acute Behavioural Disturbance and the need for data on vulnerability. Jake suggested engaging with the Royal College of Psychiatrists,

and possibly Royal College of Emergency Medicine, to better understand the issues.

14. Immigration detention: the Home Office have stated they will be adopting the Safety Impact Assessment in line with HMPPS. Kate explained that all of the recommendations from the Brook House inquiry which have been accepted or partially accepted will be included. A statutory inquiry will be looking into deaths at Manston short-term holding facility; the Panel will keep a watching brief.

15. Engagement with families: Kate will be shadowing FLO training in HMPPS and hopes to do the same in other custody sectors. She suggested running a seminar to share cross-cutting learning and to understand the barriers and how they can be overcome, and asked for help in contacting bereaved families who could participate. Andrew referenced work taking place in Australia where bereavement and coroner services are linked up; he will share information on this.

Action 3: Secretariat to provide contacts for organisations for bereaved family engagement.

16. Coroners' PFD reports: letters to custodial sectors and health trusts requesting responses to the Panel's recommendations had now all been sent. The Panel suggested asking for Georgia Richards' help in analysing the responses and the extent to which they are followed up. Lynn noted that responses so far have been disappointing and have not addressed the issues. This item will be taken forward and Andrew will bring suggested wording for the new workplan.

Action 4: Panel members to prepare wording for their items for the new workplan for the next meeting.

17. Approved Premises: The panel agreed to include a workstream on deaths in Approved Premises, which will include data on current deaths (self-inflicted and other). Probation staff will be attending the next Panel meeting to inform this process.

Item 3: Mental Health Act deaths independent investigations paper

18. The Panel noted feedback received from stakeholders and discussed incorporating it into the report. They discussed how people are referenced (the need to emphasise that they are patients), providing a copy of the report to the Royal College of Psychiatrists to formally review, and the need to soften the Article 2 argument as the Panel's proposal is meritorious on several levels. The Panel agreed that the headings are the right ones. Jake noted that the Health Services Safety Investigations Body (HSSIB) has a role to play in professionalising investigators and that the question of CQC's involvement in investigations needs to be clarified. Lynn suggested that the Dash review might shed some light. Andrew stated that the CQC are the most suitable body to take this function on; deaths of patients detained under the MHA are always complex and raise issues of significant combinations of individual and corporate failures and systems.

19. Next steps are for the Panel to review the next version of the report, set up meetings with the NHS Patient Safety Team and HSSIB, and to send the report to tier two stakeholders. A draft copy of the report will also be forwarded to Baroness Merron for discussion ahead of the meeting of the Ministerial Board on Deaths in Custody for initial feedback.

Action 5: Secretariat to resend stakeholder tier two list to Panel to finalise.

Item 4: Dash Review of Patient Safety Across the Health and Care Landscape

20. Lynn introduced Liz Jessop, who is providing support to Penny Dash's review. The final report would be published in the next few weeks.
21. Liz provided background to the review. The Dash review has been looking into whether the current range and combination of organisations involved in patient safety delivers effective leadership, learning and regulation to the health and care systems in relation to patient and user safety (and to what extent they focus on the other domains of quality). Dr Dash's review of the operational effectiveness of the Care Quality Commission, published in October, found the landscape around patient safety to be particularly confusing and the Secretary of State commissioned a further review of patient safety in six DHSC sponsored agencies. Dr Dash had gathered information and held discussions with stakeholders. The review would feed into the 10-year health plan.

Item 5: Dr Georgia Richards work re: PFDs in Australia

22. Dr Richards is a Research Fellow at King's College London and holds an Honorary Associate Tutor position at the University of Oxford. She shared her work on developing the Preventable Deaths Tracker in 2018/19 and insights from the Australian and New Zealand death investigation systems where they routinely collate data from coroners' inquests and have processes for learning and using this information to inform policy and death prevention. No comparable system exists in the UK, which was the rationale for creating the Preventable Deaths Tracker and launching it as an accessible public website in 2020.
23. Dr Richards has advanced the Preventable Deaths Tracker platform and added several new features, including making all coroners' Prevention of Future Deaths (PFDs) reports machine-readable and searchable. She is also working on a new categorisation system that will enhance the ability to identify and analyse reports, however this work requires resourcing and support. Andrew referenced a piece of research work he undertook a few years ago which he wanted to update and asked for Georgia's help. He will contact her separately.

Item 6: AOB

24. The Secretariat provided an update on staffing and funding.
25. Andrew suggested that the Panel should have routine access to a statistician in order to comment on publication of official statistics.

Next Meeting: 6 May 2025

Actions:

- Kate to share amendment to January Panel meeting minutes *(complete).*
- Secretariat to ask HMPPS for data on numbers of self-inflicted deaths and self-harm for people awaiting transfer.
- Secretariat to provide contacts for organisations for bereaved family engagement.
- Panel members to prepare wording for their items for the new workplan for the next meeting.
- Secretariat to resend stakeholder tier two list to Panel to finalise.