Independent Advisory Panel on Deaths in Custody

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Chair's end of term report

September 2024 - February 2026

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Chair's Foreword

People in detention are among the most vulnerable in society. The state has a clear and enduring obligation to ensure the safety of those it detains. Helping Government meet its duty to safeguard life has always been at the heart of the IAPDC and continues to underpin everything we do.

During my period as Chair, the custodial landscape has faced considerable change, with prisons in particular facing severe capacity challenges leading to far-reaching structural reforms. The Panel has welcomed changes to sentencing and release policy and legislation to ease pressures on critical services in prisons, but these changes must be accompanied by robust safeguards and alternative support to protect vulnerable individuals. Upon taking the role of Chair, I have sought to raise the profile of health issues across the Panel's areas of focus and mental health in particular. Through dedicated work by Panel members, I believe this has been achieved. The abolition of NHS England represents a major shift in governance: I hope the implementation of the landmark Dash review into patient safety is accompanied by increased attention to those detained under the Mental Health Act, with improvements to how they are cared for and how deaths are investigated. Panel membership of the Mortality Group, exploring the collection and analysis of mental health data, and the National Suicide Prevention Strategy Advisory Group are on-going.

In policing, the abolition of Police and Crime Commissioners in the last year brings further change, and it is vital that this does not undermine progress the Panel has supported in strengthening leadership, oversight, and scrutiny of deaths in custody over the last few years. Indeed, I hope the recent policing White Paper, 'From local to national: a new model for policing', may connect previous and current Panel work looking at what progress can be made at the national level to improve policing standards around deaths in custody. Likewise, immigration has been a particular flashpoint during my tenure, and I hope the Government's new Immigration Plan – with its increased focus on removals and therefore detentions – fully considers the risks and vulnerabilities of those detained under immigration powers and maintains and improves safeguards to prevent harm.

Against this backdrop, deaths in custody remain unacceptably high across all settings – a stark reminder of why our work is so critical. As my term as Chair draws to a close, I remain deeply committed to the IAPDC's values and it is essential that the IAPDC continues to play a vital role as an independent voice, advising Government, shaping policy, and embedding learning to prevent future deaths in custody.

Our achievements to date reflect the dedication and expertise of the Panel, and we take pride in what has been accomplished. Our reports on prison capacity, the use of ligatures within the prison estate, and detailed statistical analysis offer evidence and advice to inform decision-making. Our work on post-custody suicide prevention in policing has resulted in new guidance, embedded within all 43 police forces, setting out an evidence-informed approach to managing suicide risk in and following police custody. This has enabled ongoing work to identify risk and vulnerable individuals and implement robust release planning and clear referral pathways.

We have also published a report calling for independent investigation of deaths in Mental Health Act detention, emphasising the need for parity. I am hopeful that work on scoping the requirements to achieve this will progress. I have also pressed for improvements in timely transfers from prison custody to hospital so the recently passed Mental Health Act 2025 is a welcome step forward and offers an opportunity to address systemic delays in treatment that cost lives.

Looking ahead, our workplan for 2025/26 sets out an ambitious agenda to deepen collaboration, improve data transparency, and ensure that lessons and recommendations lead to meaningful improvements across all custody settings. My Panel members will ensure this work continues, and I hope it is reinforced through strong governance and delivery by the Ministerial Board on Deaths in Custody. Throughout my tenure, the Panel has pushed to see the work of the Board and its relationship with the Panel strengthened, as this is central to driving cross-departmental solutions and embedding learning to prevent future deaths.

Recruitment of new Panel members has been a priority. Despite delays, we have welcomed colleagues who bring new expertise and fresh perspectives. Their contributions, alongside those of departing members, have been invaluable in shaping our work. At the same time, I hope that further efforts will be made to strengthen recruitment and that the process becomes more efficient in future, so we can maintain momentum and continuity.

Preventing deaths in custody is a shared responsibility and I urge continued investment in this work. Finally, I want to thank my fellow Panel members for their dedication, our secretariat for their support, and all those who have contributed their insights and experience. It has been an honour to serve as Chair, and I leave with confidence that the Panel will continue to make a vital difference.

Lynn Emslie

Chair of the Independent Advisory Panel on Deaths in Custody

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Our purpose and remit

The Ministerial Council on Deaths in Custody (MCDC) formally began operation in April 2009 and is jointly sponsored by the Ministry of Justice (MoJ), the Department of Health and Social Care (DHSC) and the Home Office (HO). The remit of the MCDC covers deaths which occur in prisons, in or following police custody, immigration detention, Approved Premises, and detention under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital. The Council consists of three parts:

- The Independent Advisory Panel on Deaths in Custody (IAPDC)
- The Ministerial Board on Deaths in Custody (MBDC)
- The Practitioner and Stakeholder Group (PSG)

The IAPDC is an advisory non-departmental public body the role of which is to provide independent advice and expertise to Ministers, officials, and the MBDC. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

The MBDC's role is to help bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales. It meets twice a year and is chaired by the MCDC's co-chair Ministers. Its membership includes officials and service leads, the IAPDC, the Chief Coroner, scrutiny bodies, and charities and NGOs across the custody areas.

The PSG is drawn from inspectorate and investigative bodies, lawyers, third sector organisations, families, academics and practitioners from across the custodial sectors. The Panel encourages practitioners from a range of organisations, particularly mental health settings, as well as bereaved families and former detainees, to join the group.

Members of the group receive regular communication with links to relevant news and publications from across the sectors, updates from the IAPDC website and invitations to stakeholder events. It is a Panel priority to make the most of this group's expertise and shared ambition to prevent avoidable deaths. You can join the group here.

The Panel's Terms of Reference originated in Robert Fulton's Review of the Forum for Preventing Deaths in Custody (2008):

- Act as the primary source of independent advice to ministers and service leaders (both through the Ministerial Board and where appropriate directly) on measures to reduce the number and rate of deaths in custody.
- Consult and engage with Ministers and the Ministerial Board to identify the key areas of advice and research to enable the operational services to reduce the number and rate of deaths in custody.
- Consult and engage with relevant stakeholders in order to collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them
- Commission relevant research
- Carry out thematic enquiries into areas of concern, in co-operation as appropriate with the relevant oversight and investigative bodies
- Issue formal guidance (and where appropriate set common standards) on best practice for reducing deaths in custody, both on its own authority and where appropriate under the authority of the Ministerial Board
- Monitor compliance with such guidance and standards
- Where appropriate, make recommendations to ministers for changes in policy or operational practice, which would help to reduce the incidence of death in custody.

Strategic principles

In order to prevent deaths within our remit, the IAPDC will:

Approach to advice

- Seek to enable Ministers to meet their human rights obligations to protect life;
- Provide advice that is strategic and implementable by those receiving it;
- Promote the adoption and implementation of its advice.

Working practices

- Draw on the Panel's knowledge and experience of relevant issues;
- Draw on research evidence to underpin its work and identify gaps in knowledge;
- Build on prior work and avoid duplicating work being undertaken elsewhere;
- Recognise that – as a small independent non-departmental public body with limited resources – it should work strategically.

Guiding principles

- Wherever possible in developing recommendations and advice, consult people in custody, their families or significant others, and bereaved families;
- Place equality and diversity at the heart of its work;
- Work within and draw upon the UK's domestic and international human rights framework.

Relationship to co-sponsoring departments and wider stakeholders

- Embrace the cross-departmental nature of its remit and seek involvement at an early stage with departmental initiatives;
- Develop strategic partnerships and work collaboratively with stakeholders to share information and knowledge.

Our work

The IAPDC's sole purpose is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales. To do this we work closely with Ministers, co-sponsoring departments and agencies to provide expert advice on how they can meet their human rights obligations to protect life.

This report covers the second half of Lynn Emslie's tenure as Chair, which began in February 2023. The Panel has published three workplans during this period: April-October 2023, 2024-2025, and 2025-2026. For a breakdown of the work accomplished by the Panel during the first half of Lynn's tenure, see the Panel's mid-term report, published in November 2024.

Mary the Pidgeon, Atkinson Secure Unit (secure children's home), Commended Award for Printmaking.
We are grateful for permission from Koestler Arts for the use of this image

Cross-cutting work

The Panel has a unique role in working across custodial settings and department and agency boundaries. During this period the Panel has demonstrated this approach through work to enhance the preventative potential of coroners' Prevention of Future Deaths reports and continued to provide advice to sectors on constructive engagement with bereaved families.

Supporting learning and best practice for family liaison following deaths in custody

> *"...the unique perspective of bereaved families is invaluable to custody sectors in ensuring that the right questions are asked and all necessary action to prevent future deaths taken".*
>
> **Lynn Emslie.**

All custodial institutions have a duty to engage sympathetically and respectfully with families while waiting to hear the outcome of any investigation and/or inquest following a death. Families' involvement in investigations enables the custody sectors to get to the truth, gathering the family's perspective on the events in question, their loved one's treatment, and how they themselves have been treated by custody services. These basic principles have been underscored by numerous reports in deaths in custody, including the Harris Review and the Dame Angiolini Review.

The Panel has undertaken several exercises since 2019 to determine what policies custodial sectors and scrutiny organisations have in place for engaging families following a death in custody. Following such an exercise in 2021, the Panel concluded that in some instances the organisation's own publications detailed that many families were not happy with the level of engagement and support they received.

In light of this, in 2023 the Panel wrote to leaders of all custodial sectors and scrutiny organisations to highlight some minimum steps they should take to ensure that all family members are treated with the respect and dignity they deserve, including:

- Policies and guidance on sympathetic, constructive engagement with families should be easily accessible and available to all staff;
- Families should be informed as soon as possible after a death and information delivered by properly trained staff with sensitivity and compassion, providing clear guidance on bereavement services and independent sources of advice;
- Documentation for families offering support and advice on what they can expect from an investigation and inquest, including support they can expect to receive, should be centrally stored and given to all bereaved families;
- A log must be kept of all communication with the family, including when advice/guidance was given to them.

Custodial sectors wrote back to us to advise on steps they had taken and issues they encountered.
A summary of themes from the responses were:

- All sectors who responded said they had clearly defined processes in place, and developed their own leaflets for families following a death in custody, many available in hard copy only;
- All sectors provide training for their family liaison staff. Detention Services and HMPPS staff receive the same four-day training course;
- It was noted that families experiencing a death in prison may have contact with numerous Family Liaison Officers (FLO) including those of the prison, the Prison and Probation Ombudsman (PPO), police and Coroner's office, creating the potential for conflicting information, misinformation, and confusion over the roles of the different FLOs.

In order to understand the skills required and the challenges faced by staff who serve in the role, IAPDC member Kate Eves has started a programme of undertaking FLO training provided by the different custodial sectors, providing initial feedback and taking examples of best practice. Kate has also been liaising with the charity INQUEST to understand the work they do with families and to engage them in a future project involving families in an event to promote cross sector learning and best practice, and to provide support for those who engage with families in all organisations. The event is expected to take place in Spring 2026.

Reviewing and improving the impact of coroners' Prevention of Future Deaths (PFD) reports

> *"PFDs are vitally important if society is to learn from deaths…a bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it's less likely to happen to somebody else."*
>
> **Chief Coroner's Guidance on Reports to Prevent Future Deaths**

At the end of an inquest, coroners produce a PFD report when they believe action should be taken by an individual or agency to protect lives. These reports can be vital tools to identify areas for improvement and change for custody services to ensure lessons are learned from deaths in detention.

The IAPDC and others have repeatedly raised concerns around the production and sharing of PFD reports as well as the responses to them by custody services, finding that practice in these areas could be strengthened.

The IAPDC's submission to the Justice Select Committee in September 2020 called for a strengthening of the coroner's role by making full use of PFD reports to learn lessons and better prevent future deaths. In September 2023, we published our report, "More than a paper exercise" – Enhancing the impact of Prevention of Future Death Reports". This was based on a sampling exercise of PFD reports detailing deaths across all places of state detention as well as a roundtable with coroners to explore the purpose of these reports, how the drafting, publication, and distribution of reports could be improved, and how learning from reports could be maximised. The report found several factors were limiting the effectiveness of PFD reports to prevent custody deaths and made a series of recommendations to improve PFD processes and practices, including:

- PFD reports should be viewed as opportunities to improve practice and should be shared as widely as possible to inform local and national learning;
- Clear guidance and training should be developed to improve the PFD process and enhance the impact of the reports;
- Adequate funding is needed to enable the Chief Coroner's Office to better carry out its research and oversight functions to encourage progress following publication of PFD reports.

Since publication, the Panel has sought to follow up on its report to identify how practice in this area may be changing and what challenges remain. In February 2025 the Panel wrote to 43 government departments and other organisations to ascertain their responses to the recommendations and areas of good practice. The responses provided a mixed picture of improvements and continuing challenges and aided the Panel in identifying further areas of focus. The Panel also met with both the current Chief Coroner and her predecessor for their views which fed into the information for focus areas. The Panel are now seeking to identify and monitor themes arising from deaths in detention, working with Georgia Richards of King's College London and her Preventable Deaths Tracker to create a new database of PFD reports relating to deaths across all custody settings, and use it to identify the effectiveness of the actions taken to prevent deaths.

Immigration detention

Improving the operation of safeguards within immigration detention

The immigration detention population is inherently diverse, with individuals often having complex needs which span physical health, mental health, and wellbeing. Our 2020 report on preventing deaths in immigration removal centres (IRCs) – which was commissioned by the Home Office following Sir Stephen Shaw's second review of immigration detention – found that people in immigration detention are particularly vulnerable to harm due to heightened feelings of hopelessness and uncertainty.

Total numbers of deaths within immigration detention currently remain low relative to other custody settings. However, improvements to safeguards for vulnerable people are urgently needed to help lessen the risk of further preventable deaths. We have therefore engaged with officials in the Home Office who are looking more closely at Rules 34 and 35 of the Detention Centre Rules, which are designed to ensure the welfare of individuals in immigration detention, and provided input and feedback on the Adults at Risk policy.

Alongside this, an emergency code pilot is underway at Yarl's Wood IRC, led by NHSE, to review the use of Codes Red and Blue in IRCs. Dr Jake Hard has participated in discussions as part of this work, providing clinical insight where appropriate. The Panel's flagship Safety Impact Assessment (SIA) tool, developed under the previous IAPDC Chair, is being used in this pilot and is also under consideration as part of the expansion of the estate. The Panel continues to emphasise that the SIA should inform both physical infrastructure changes and all policy decisions that impact safety.

Following our 2020 report on preventing suicides in IRCs, we recommended that the Home Office conduct research comparing remand, IPP prisoners and others serving indeterminate terms with those detained in IRCs to further understand the impact of uncertainty and hopelessness. We also called for greater understanding of cultural differences in suicide prevention strategies and for learning on childhood trauma to be collated and shared to inform best practice and reduce the risk of suicide and self-harm. The Home Office agreed to undertake this research and is now finalising the work, with an update expected in January 2026.

The Panel has also supported former IAPDC Chair Juliet Lyon CBE in giving evidence to the public inquiry into the decisions, actions and circumstances which led to the conditions encountered by those detained at Manston Short-Term Holding Facility between 1 June 2022 and 22 November 2022. Juliet's evidence relates to her visit to the facility before that period, in May 2022, and letters she wrote to the then-Immigration Minister in October and November 2022 following public evidence as to the drastic deterioration in conditions there in October 2022. Chair Lynn Emslie subsequently visited the site in February 2024.

Prisons

Addressing challenges of prison system capacity impacting on deaths in custody

"Our modelling shows that while the prison population is projected to grow by 13% by 2029, self-inflicted deaths are expected to rise by 21%. It is important that measures are in place to focus attention on these parts of the prison estate that are projected to disproportionately higher increases in deaths such as Category B prisons."

Professor Seena Fazel, Panel member.

The first duty of detention services is to keep those in custody safe. It cannot do so if an increasing population leads to systemic overcrowding, placing pressures on the very services – such as healthcare, suicide prevention, and security – designed to keep those in detention safe. Although the prison population has fluctuated over the past decade, in recent years the prison estate has officially been classified as overcrowded. For too long it has operated at around an unacceptable 99% of its Usable Operational Capacity, with emergency measures triggered to ease prison overcrowding by using police cells to house prisoners. As the Panel has warned over the last few years, these pressures within the prison estate have raised serious questions as to whether His Majesty's Prison and Probation Service is able to keep those in its custody safe. This includes ensuring good mental wellbeing through appropriate levels of time out of cell, the provision of meaningful activity, including education and employment, and regular keywork sessions as well as access to healthcare, Samaritans Listeners and Buddies.

While the most recent statistics suggest this percentage has thankfully decreased, the latest projections from the Ministry of Justice (MoJ) indicate that the prison population will increase by over 12,000 individuals by 2029, reaching approximately 100,800. Many prison facilities are still operating above their intended capacity, raising continuing concerns about the impact of sustained overcrowding on prisoner safety.

To avoid capacity crises in the future – and the unacceptable yet inevitable consequences for prisoner safety – it is vital that Ministers and policymakers (i) properly understand the impact of decisions on the prison population; (ii) address the safety implications of increases in prison numbers for prisoners and staff; and (iii) proactively mitigate adverse safety impacts. In early 2025, the IAPDC undertook research to create a model of what impact population pressures and overcrowding may have on the safety of prisoners in the future. Using advanced modelling techniques, the Panel's report looked at what is known about the expected increase in population numbers over the next five years and the impact of this on deaths, including variables such as population type (for instance remand prisoners).

Projections from the report - 'Prison overcrowding and deaths in England and Wales' – are stark: while the prison population is expected to grow by 13% between 2025 and 2029, self-inflicted deaths are expected to rise by 21%, a disproportionately higher increase. The empirical modelling suggests that prisons operating above capacity experience significantly higher rates of self-inflicted and natural deaths, particularly in Category B prisons. Multiple factors may explain these concerning connections, with overcrowded prisons less able to deal with self-harm and suicidality and not fully meeting increasing healthcare and staffing pressures.

Key findings from the report include:

- Overcrowding is systematically associated with increased mortality across most prison categories, especially for self-inflicted and natural deaths;
- Mortality patterns differ substantially across prison categories, with self-inflicted deaths strongly linked to overcrowding in closed male facilities;
- Category B prisons are projected to experience disproportionately high numbers of deaths, particularly self-inflicted deaths, highlighting the need for targeted healthcare and suicide prevention interventions in these settings;
- If current trends continue, total annual deaths in custody are projected to rise from 319 in 2025 to 359 by 2029. Self-inflicted deaths are expected to increase by 21%, and natural deaths by 12%. Most of these deaths are expected to occur in Category B and C prisons;
- By 2029, a conservative estimate suggests that 145 deaths in custody, approximately 40% of the total, will result from external causes, including suicide, overdoses, and other potentially preventable events.

The Panel recommended several steps for HMPPS to take to address the challenges of an increasing prison population on safety:

- Expand healthcare provision, particularly mental health services, in high-risk environments such as Category B male prisons;
- Target suicide and self-harm prevention in prisons with occupancy rates at or above 100%;
- Enable establishment-level research by allowing routine data sharing with independent research teams to better understand mortality risks and how to mitigate them.

The Panel continue to engage HMPPS on ways of expanding their model with additional, more fine-grained data to ensure these findings can further inform custody leaders as part of their long-term strategy to successfully and safely manage the increasing population in the prison estate.

The Panel have also focused on specific capacity and safety challenges across the estate. For example, they have become increasingly concerned about the rise in homicides and overall violence. With two recent homicides in HMP Wakefield, where an HMIP inspection report prior to the incidents highlighted a 72% increase in serious assaults, the Panel have raised concerns about the use of dedicated wings for Vulnerable Prisoners and the risks to their safety when outside them, and the impact that capacity pressures may be having on decision-making in this area. The IAPDC has written to the DGO of HMPPS to understand what the service is doing to analyse patterns to inform a preventative strategy and address these issues.

Developing a national approach to ligature reduction in prisons

"Our report seeks to bring the critical issue of ligature deaths in prisons to the forefront and provides a foundation for meaningful and lasting reform in their prevention. We urge the Government and prison leaders to act on these findings and recommendations."

Lynn Emslie, IAPDC Chair.

Deaths involving the use of ligatures account for the vast majority of suicides in prisons in England and Wales. More must be done to prevent these tragic and often avoidable deaths. But they are a complex problem, particularly in a custody setting that faces systemic challenges where ligatures may only be one part of the risk picture. Any solution must form part of a broader, holistic, and multi-disciplinary approach.

In August 2025, the Panel published its research paper, 'Ligature deaths in prisons in England and Wales: trends and reduction strategies'. The report provides a summary of all ligature deaths in prison custody in England and Wales from 1999 to 2024 and an overview of ligature prevention strategies for prisons informed by existing frameworks, guidelines, and international research evidence.

Key recommendations from the report were grouped into four common themes:

- Establishing a national and coordinated approach to ligature death reduction;
- Enhancing safety through design, materials, and maintenance while preserving dignity;
- Establishing structured monitoring and information sharing for ongoing risk management; and
- Facilitating research in prisons to inform effective prevention strategies.

In September 2025, the IAPDC presented this paper at a Policy Forum held by the MBDC, leading a discussion on the following issues: the challenges and practicalities in removing ligature risks; identifying risks through regular audits; addressing the greatest risks to reduce immediate harms while balancing decency and dignity; data, learning, and research; and the role of a national strategy.

Following this discussion, the Panel continues to engage Ministers and officials on its core policy concern of developing a national strategy for reducing ligature deaths across prisons in England and Wales. Over the next year, the Panel will seek to gather further evidence and insight from across the prison service and nationally to develop its proposals further. It presented on these issues at the most recent meeting of the MBDC in November 2025 and has followed up with a letter to Lord Timpson about the development of a national strategy for ligature reduction in prisons.

Investigating access to mental health provision in prisons

Prisons do not hold a representative section of the wider population – those in custody have significantly higher rates of mental health need, drug and alcohol addictions and rates of suicide and self-harm. For many people in prison, mental health conditions have played a significant part in their offending history, yet the support they receive, both before, during and after prison continues to be variable.

The Panel strongly welcomes the passage of the Mental Health Act, particularly its introduction of a time limit on transfers from prison to hospital for mental health treatment as well as its ban on the use of prison as a 'place of safety' for those in mental health need. However, the Panel continues to be very concerned about the ability of prisons – still facing significant capacity pressures that impact on service delivery across the estate – to provide the healthcare that many of those serving sentences need, not only to effectively progress their sentences but to stay safe while in custody.

The Panel is very keen to monitor the implementation of the Mental Health Act to ensure it makes a real difference to those with mental health need in prison. We continue to have valuable discussions with officials around how this can be done. As part of this, the Panel has undertaken a programme of work to investigate access to mental health provision in prison. In November 2025, IAPDC member Kate Eves carried out an initial review of the 25 most recently published PPO investigation reports into self-inflicted prison deaths to ascertain levels of care for mental health the deceased received prior to their death.

Her initial review identified a number of key themes for further exploration. These included: in 64% of cases the deceased was the subject of the Assessment, Care in Custody and Teamwork (ACCT) framework at the time of or shortly before their death; while in 8% of cases the deceased was on a waiting list for mental health treatment, in 20% of cases the deceased was not but the facts of their cases may indicate they should have been; and in 36% of cases the clinical reviewer found the care they received to not be equivalent to what would be expected in the community.

The Panel intend to follow up on this initial review to explore a range of themes and issues arising from it, including how these reports (and the clinical reviews that contribute to them) examine and assess mental healthcare. The Panel are continuing to have valuable discussions with officials about how to monitor these issues from both the healthcare and scrutiny perspectives, and intend to engage the PPO and others on next steps arising from the issues identified in the initial review.

In connection with this work, the expertise of Panel members Professor Seena Fazel and Dr Jake Hard was recognised in their contributions to the Chief Medical Officer's recent report, 'The health of people in prison, on probation and in the secure NHS estate in England', published 6 November 2025. As well as contributing significantly to several other sections, Professor Seena Fazel wrote the chapter, 'Self-harm and suicide in prison' in which he looked at the trends and risk factors for suicide and self-harm as well as the impact on prisoners and staff. He made several recommendations including reducing access to means to prevent suicide and introducing structured and evidence-based approaches to assess and manage risk in people who have self-harmed in custody. He also noted that research is key to providing a robust evidence base to inform clinical practice but that undertaking research in prisons is complicated by practical problems, delays in prison service approvals, and increasing administrative burden on researchers. These include difficulties with recruiting sufficiently large sample sizes to detect meaningful differences for self-harm and resource and other difficulties in studies that follow people over time. In addition, the facilitation of independent research should be prioritised by the prison service so that key evidence gaps can be addressed, and evidence-based findings implemented.

Dr Jake Hard (with Donna Gipson of EP:IC Consultants and Angelique Whitfield of NHS England) wrote the chapter, 'Data and information sharing for health in the criminal justice system'. The chapter looked at two overarching issues which had relevance within the wider report, that of personal data for individual care and aggregate data for surveillance and research. Dr Hard noted the duty to share information between different healthcare providers and across legal and commercial boundaries was hindered by lack of staff confidence and clarity on what should be shared and with whom, with challenges in accessing the multiple existing systems. He made recommendations to address these issues and highlighted the importance of cross departmental leadership.

The Panel intends to follow up with officials across the MBDC to ensure the recommendations of the report are implemented to improve suicide prevention and healthcare for prisoners across England and that this leads to significant change.

Submissions and other work

Justice Select Committee inquiry on 'the Coroner Service: follow up' (January 2025)

The original JSC inquiry on the effectiveness and capacity of the Coroner Service was carried out in 2021. The follow-up inquiry in 2025 was set up to consider what had changed in the Coroner Service since 2021, checking in particular on the progress on the Committee's earlier recommendations. The IAPDC's evidence recognised that some progress has been made, including the removal of the means test for Exceptional Case Funding for bereaved families involved in Article 2 inquests. We welcome the proposals for establishing equity in legal representation for families in inquests, proposed in the Public Office Accountability Bill 2025. We called on the government to now work with all those involved in the inquest and PFD processes to build on this progress and ensure adequate mechanisms were in place to identify, disseminate, and embed learning when a death in custody occurs. We highlighted the importance of bereaved families being at the heart of the coroner service and be given confidence that all parties involved will work together to ensure these processes are fully effective and that PFD reports live up to their name in preventing deaths.

Justice Select Committee inquiry on 'tackling drugs in prisons' (January 2025)

The Justice Committee launched this inquiry to examine the scale and impact of drugs in prisons in England and Wales, including the primary factors driving demand and to consider the implications of drug misuse in prisons for safety, security, staffing and prisoner well-being. The IAPDC response to the inquiry noted that far too many people are imprisoned for drug-related offences and that opportunities to divert offenders with pre-existing drug misuse issues away from custody and into treatment should be maximised. We were clear that for those for whom imprisonment is necessary, treatment should begin at the start of their sentence and continue throughout their custody journey and in preparation for their release, and that drug misuse should not be viewed in isolation but as part of wider health and social care and support needs. We called for a whole-system approach to addressing the causes of drug misuse and promoting effective treatment and recovery; and for increased investment in research to understand the effects of psychoactive substances, develop successful detection methods, and inform effective interventions – leading to better resourcing and treatment options.

Inside Time

Lynn Emslie has continued to contribute articles to the prison journal Inside Time. Below are her published articles over the second half of her tenure:

- Why we must ensure early release doesn't lead to more people back in prison, 1 October 2024
- Supporting the remand prison population, 16 December 2024
- Driving improvements to safety through the Independent Sentencing Review, 11 February 2025
- Supporting people in prison with drug misuse issues, 8 April 2025
- Mental Health Bill: Time for change, 23 June 2025
- Strengthening connections and continuity of healthcare, 15 August 2025
- Behind the numbers: how overcrowding can impact people in prison, 13 October 2025
- Inside the walls: why prison conditions matter, 8 December 2025.

Lynn received many letters from prisoners in response to her articles. These letters highlighted their experience of prison on a range of themes including access to healthcare, substance misuse, time out of cell, keyworking, and the condition of the prison estate. Lynn responded individually to each letter.

Policing

Improving access to support to better prevent post-police custody suicides

> *"Every person who enters police custody deserves to be treated with dignity, compassion, and care."*
>
> **Chief Constable Ivan Balhatchet, NPCC Lead for Custody and Movement of Prisoners**

Annual statistics published by the Independent Office for Police Conduct (IOPC) consistently highlight a deeply troubling number of apparent suicides following police custody, most occurring within two days of release. In 2024/25, this figure reached as high as 60. While suicides in custody suites remain rare – with one recorded in 2023/24 and the previous such death in 2016/17 – it is vital to ensure that suicide risk is identified and appropriately managed throughout custody and after release. The experience of custody itself can significantly influence a person's risk of suicide after release, making it essential to assess and address support needs from the point of arrest through to release.

Following our joint roundtable event with the National Police Chiefs' Council (NPCC) in 2024 on preventing suicide following police custody (see the last mid-term report), the IAPDC established a Working Group with the NPCC, College of Policing (CoP) and representatives from policing, health, and third sector organisations. The purpose of this group is to support the implementation of recommendations from the roundtable and from our 2022 report on 'Preventing deaths at the point of arrest, during and after police custody'.

The Working Groups have helped shape two key strands of this workstream :

- The first strand was to develop good practice guidance for inclusion in the current CoP authorised professional practice (APP) on 'Detention and Custody'. The 'Guidance on preventing suicides in and following police custody in England and Wales', published in October 2025, provides a clear framework for police forces across England and Wales to embed suicide prevention in every stage of the custody process. Its effective implementation depends on prioritising effective risk assessment, partnership working, trauma-informed care and robust release planning. To ensure accountability and transparency, this document emphasises the role of scrutiny panels, independent custody visitors, and regular monitoring. Embedding this guidance successfully will require not only operational changes but also a cultural shift towards collaborative working across sectors, with shared responsibility for safeguarding those at risk.
- The Panel's work with the Association of Police and Crime Commissioners to develop their 'Guidance of preventing deaths in police custody and suicides following release', and the revised version 2025, supports this work.
- The second strand is the construction of information-sharing agreements between police forces and local partners (for discussion and development) which are critical to ensuring timely and appropriate care for vulnerable individuals. Clear referral pathways and sustained post-custody support are critical to ensuring vulnerable individuals receive the support they need – not just in custody, but beyond release.

In addition, the IAPDC have been working with the NPCC, CoP and Independent Office for Police Conduct (IOPC) to convene an insight session in February 2026. The purpose of this is to examine interim findings and methodology from the NPCC's ongoing data collection exercise on post-custody suicides. This exercise spans all 43 police forces and aims to identify common patterns among individuals who died by suicide following police custody. The dataset builds on IOPC records – which include demographic details, substance use, mental health concerns, offence type, use of force, and circumstances of death – to provide a more comprehensive understanding of risk factors and vulnerabilities. IOPC analysts will present their findings and draw on the expertise of attendees to shape the analysis into a future report.

Examining the use of force during arrest

Dame Angiolini DBE KC's 2017 'Independent Review of Deaths and Serious Incidents in Police Custody' identified police restraint deaths as one of the most serious categories of deaths in custody and highlighted that many of those who die following the use of physical restraint suffer from mental ill-health. The review made a series of important recommendations regarding use of force to reduce restraint deaths in custody. Restraint deaths remain a significant cause of concern, particularly deaths involving people experiencing mental ill-health. The latest IOPC statistics for 2024/2025 note that five of the 17 people who died had some force used against them by officers or members of the public before their deaths. The Panel drew on the important findings of this landmark report as part of its response to the Home Office's 2024 review of investigations into the use of force (see the last mid-term report).

In 2025, the IAPDC began a literature review of deaths following the use of force. This includes deaths occurring after detention or arrest under section 136 of the Mental Health Act, as well as those involving restraint and including questions of disproportionality. The review is exploring the causes and management of deaths following the use of restraint, with a particular focus on clinical and operational factors, especially in cases involving Acute Behavioural Disturbance (ABD). The review seeks to define and scope the terms 'use of force' and 'restraint' to understand reasons for different usages. The final review report will also include an international dimension and analysis of any published investigations into restraint-related deaths to identify patterns and causative restraint methods.

People detained under the Mental Health Act

Improving investigations of deaths in MHA detention

> *"Deaths of patients detained under the Mental Health Act 1983 are not subject to any independent investigation in the same way as deaths in police custody (Independent Office Police Complaints) [sic] or in Prison (Prison and Probation Ombudsman)…Therefore critical learning and evidence is being lost which may prevent future deaths."*
>
> **Coroner Jeanne Kearsley, Prevention of Future Deaths report into the death of Charlie Millers, 26 May 2024**

As the Panel's statistical reports continue to demonstrate (for the latest report, see here), rates of deaths for those detained under the Mental Health Act continue to be disproportionately high, with the highest mortality rate for any custody setting – three time higher, in fact, than that for prisons. Despite this, there remains no independent mechanism for investigating deaths that take place in that setting, with mental health trusts themselves responsible for carrying out or commissioning their own investigations – a system that bereaved families have criticised as akin to them "marking their own homework". This is in contrast to deaths in prison, police custody, and immigration detention, all of which are investigated by an independent body prior to coroners' inquests.

For over 10 years, the IAPDC has raised concerns about this disparity. Independent investigations are vital for establishing what happened, ensuring accountability, and encouraging learning. One of the Panel's priorities in our 2024-2025 workplan was to scope out the establishment of an independent investigative body that could fulfil this vital role. The Panel then took forward a dedicated programme of work to identify ways of improving the investigation of deaths under the MHA to maximise learning, transparency, and accountability, as well as exploring improvements to clinical reviews and via partnership working with existing health bodies.

Published in September 2025, the Panel's report, 'Investigating deaths under the Mental Health Act: The need for independence and parity', looks at the current system of investigations, challenges with investigations and data, and alternative models for improving investigations. It recommends establishing an independent investigative mechanism, drawing on current expertise and resources across detention settings, including clinical leadership and collaboration with expert organisations such as the Parliamentary and Health Service Ombudsman, the Health Services Safety Investigations Body and regulators like the Care Quality Commission (CQC).

Establishing an independent mechanism would ensure parity with other detention settings and support coroners in fulfilling the UK's obligations under Article 2 of the European Convention on Human Rights (ECHR) – the right to life – while providing vital data to monitor and prevent deaths. Independent investigations would also support healthcare providers in learning from deaths and ensuring that themes and issues identified in these investigations are not missed.

Panel member Dr Jake Hard presented the early and published findings and recommendations of the report at two MBDC meetings in July and November 2025 and he and Chair Lynn Emslie have had valuable discussions with Ministers and officials around the Panel's concerns in this area. Recent developments within the healthcare landscape have created a significant opportunity to look again at how investigations are delivered, following the recent 'Review of patient safety across the health and care landscape' conducted by Dr Penny Dash which identified continuing challenges in delivering safe and effective care. As the Government looks to implement the review's recommendations and its 10-year plan for the NHS, following the abolition of NHSE, the Panel hopes progress can be made towards implementing the core of the report's recommendations to improve investigations of deaths of those detained under the Mental Health Act.

Approved Premises

Mapping the safety landscape in Approved Premises

Approved Premises (APs) are residential units providing a temporary placement in the community for high-risk and complex people on probation. APs seek to help rehabilitate and resettle those who have committed serious offences and to make sure that the public are protected during an individual's early months in the community. Individuals are usually required to reside there for up to 12 weeks.

There were 12 deaths of offenders with residence in Approved Premises in 2024/25, the same number of deaths as in 2023/24. Since 2010/11, the number of deaths of individuals residing in Approved Premises has fluctuated, reaching a peak of 21 deaths in 2019/20. The IAPDC are conscious that the MBDC and the Panel have focused less attention on APs than other areas of custody, such as prisons, in recent years. While numbers of deaths remain low, APs face similar challenges to other parts of the justice system and in particular face knock-on impacts of prison overcrowding, raising similar safety risks for those in their care. The Panel welcomes the increased scrutiny being now given to APs by His Majesty's Inspectorate of Probation with its new programme of inspections of these facilities beginning in 2025.

As part of the Panel's current workplan, we are mapping and evaluating current safety measures to prevent deaths in Approved Premises and the procedures in place following a death or 'near miss'. Chair Lynn Emslie recently visited an Approved Premises to deepen the Panel's understanding of the challenges facing this custody area.

The Panel

Chair:

Lynn Emslie

With a career covering acute healthcare, mental health, health in criminal justice and local authority social services, Lynn holds several Chair, non-executive director, advisor and trustee roles across the charitable, research and regulatory sector. Focusing on mental health and people with complex needs, Lynn has championed the requirement to improve access to services, based on a person-centred approach, and reduce health inequalities.

Working strategically across the Department of Health and NHS, Lynn worked to inform policy by linking academic research into service development, including the voluntary and private sectors. She has led NHS commissioning and quality monitoring within NHS England, supported the implementation of the Assessment, Care in Custody and Teamwork (ACCT), the care planning process for prisoners at risk of suicide and self-harm, and worked with the Prisons and Probation Ombudsman on Death in Custody clinical reviews.

Lynn now works independently, in a range of roles including being a trustee at Nacro, a social justice charity.

Panel:

Dr Jake Hard

Jake is a GP with over 19 years' experience of working in prison and is the Associate Clinical Director for the South West Prisons, Oxleas NHS Foundation Trust. He was the Chair of the Royal College of General Practitioners Secure Environments Group from 2016 to 2022 and has published work with the IAPDC. He was also the Clinical Lead for the NHSE Health & Justice Information Service from 2013-2024.

Panel:

Professor Seena Fazel

Seena is the Professor of Forensic Psychiatry and Director of the Centre for Suicide Research at the University of Oxford. He is an honorary consultant forensic psychiatrist for Oxford Health NHS Foundation Trust and works clinically in a local prison. His main research interests are in relation to suicidal behaviour in prisoners, the mental health of prisoners, and risk assessment in criminal justice and mental health.

Panel:

Kate Eves OBE

Kate was the Chair of the Brook House Inquiry until January 2024, investigating mistreatment at Brook House Immigration Removal Centre. Prior to this she was the Senior Advisor to the Prison Rape Elimination Act Resource Centre in the USA and has worked as an Assistant Ombudsman (Head of Suicide and Homicide Investigation Team) for the Prisons and Probation Ombudsman and as a Researcher for HM Chief Inspector of Prisons. She has also previously worked as First Secretary to the Forum for Preventing Deaths in Custody.

Panel:

Andrew Harris

Andrew retired in 2025 after 13 years as Senior Coroner for London Inner South and Assistant in South London. He has sat on over 60 inquests into deaths in detention. In 2016 he was called to give evidence to the Independent Review of Deaths in Police Custody (Angiolini Report). He is an Honorary Professor in Coronial Law at William Harvey Research Institute, Queen Mary University of London and is dually qualified in medicine and law, having practised as a paediatrician, GP and public health consultant, and with a Masters in Public Law. He has published in various journals, on unnatural deaths and on suicide inquests, and is author of four chapters of the standard law textbook "Jervis on Coroners". He has researched therapeutic jurisprudence in international coronial jurisdictions and lectured widely in England and Australia.

Secretariat

The IAPDC is supported by a small secretariat made up of civil servants based in the Ministry of Justice. The Secretariat exists to undertake research, draft documents, liaise with departments and wider stakeholders on behalf of the IAPDC and champion its work. You can contact them here.

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in Custody

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Chair's end of term report

September 2024 - February 2026