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

Independent Advisory Panel on Deaths in Custody

Minutes of the Independent Advisory Panel meeting
05 June 2018

Attendees: **Juliet Lyon (JL) - Chair,**
Dr Meng Aw-Yong (MAY)
Professor Graham Towl (GT)
Dr Dinesh Maganty (DM)

Andrew Fraser (AF), Head of Secretariat
Kishwar Hyde (KH), Deputy Head, Secretariat
Adrian Blake, Policy Advisor, Secretariat

Apologies: Stephen Cragg QC (SC)

Welcome and minutes of the last meeting

1. The Chair welcomed DM, GT and MAY to the meeting. Apologies were received from SC.

2. Minutes of the previous meeting were accepted.

Action log

3. There were two outstanding actions from the previous meeting:

- *SC to draft a letter to NHS medical directors about IAP concerns over NHSE paper: "National Guidance on Learning from deaths"*

- *DM to produce a paper on status of mental health patients*

4. The Chair explained that she had written to the Secretary of State in February about the issue of accountability for deaths in custody but had not had a response to date. She was meeting with Rory Stewart MP next week so will raise the matter with him.

5. Following a lengthy appointment process, the new panel members will be taking up post on 1 July. The new members are:

    - Deborah Coles, Director at charity Inquest

- Jenny Talbot, Mental Health lead at Prison Reform Trust
- Jenny Shaw, professor at Manchester University
- Seena Fazel, psychiatrist at Oxford University
- John Wadham, Chair of the NPM (and previously at Liberty)

Top ten recommendations

6. AF reminded the panel of the background to this work. The panel input into the first iteration of the paper and a workshop with the scrutiny bodies took place in January; this draft was presented to the Ministerial Board in February who also commented on it. The paper has been sent back to scrutiny bodies for further revision and a near-final version will be presented to the next Ministerial Board later this month.

7. The Chair wanted to encourage colleagues to look at the issues holistically and asked for feedback on the recommendations. Comments received were:
    - managing transitions was particularly important as these were times of inflated risk of suicide
    - the services needed proper suicide assessment
    - the greatest number of deaths were from natural causes so dealing with these first would make the most impact
    - the recommendations could be split by custodial services (favoured by the Ministerial Board)/method of death/learning methods.

IAP response to inquiries/consultations:

<u>Mental Health Act review</u>

8. The review is now in the second phase and is closing soon so the IAP will need to submit comments very quickly. Cardiovascular deaths are the largest number of deaths in custody in MH units.

9. The second phase of the review is about investigation. Comments from the panel were:
    - recommend that DH look at their Article 2 compliance responsibilities
    - the MHA looks at every aspect of a patient's stay in hospital but does not look at deaths
    - While public sector investigations are usually carried out by the hospital concerned, the private sector holds <u>no</u> investigations into deaths
    - What restrictions are people under when in MH units?
    - Community Treatment Orders (CTOs) are a recent development. Many patients are under a CTO and these are disproportionately black men.
    - Recommend that an ALB should be created to build independence into investigations into MH deaths.

10. DM agreed to draft a response to feedback to the review.

Action 1: DM to draft a response to the Mental Health Act review

HSC: prison healthcare

11. The review is not accepting submissions after tomorrow. The panel wanted to feedback:
    - Compassionate release/ROTL is a neglected area
    - Vacancies and high turnover lead to staff not knowing the patients well and therefore not handling the issues effectively
    - Sub-contracting staff means the service is paying out much more than it needs to
    - There should be no maximum period of waiting for treatment.

12. The Chair will draft the IAP submission.

Action 2: JL to draft submission to Prison Healthcare review

JSC: Prison population 2022 inquiry

13. The review has not closed and the inquiry is keen to hear from the IAP. The Chair encouraged panel members to send their comments to the Secretariat as soon as possible.

Action 3: Panel to send their comments to the Sec on the Prison Population Inquiry for collation and submission

IAP focus on accountability

14. The Chair explained that this item arose from the idea that in a system where deaths in custody tend to rise and fall, a question rose about how to achieve a consistent approach. AB is looking at how the Prison Safety Impact Statement works and how rigorous is the approach. It was important to keep up pressure and keep deaths in custody an ongoing concern. One approach may be to report on deaths to Parliament annually via an organisation like the Justice Select Committee; the IAP would also lend their comments to this report.

IAP – looking back, and forwards

The Chair asked the panel members what they think the new IAP could and should do, bearing in mind that there will be more scope with more members and more time. Panel members suggested:

- The time has to be used strategically
- Immigration enforcement is under-scrutinised
- The link between self-harm and self-inflicted death needs investigating
- Natural-cause deaths
- An office for Article 2 compliance.

AOB and finish

The Chair expressed her thanks to the panel members for their work over the past four years (and hoped that they would continue to contribute to the future work of the IAP through the stakeholder group.)