IAPDC

NEWSLETTER

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FOREWORD FROM OUR CHAIR, LYNN EMSLIE

It has been a busy eight months. I can honestly say that we are all working very hard to ensure the message about preventing deaths in custody is heard very loudly by all services and policy leads directly involved in the agenda.

However, I am also keen to raise awareness with people who are not directly involved but whose roles and actions affect outcomes for people detained by the state. I am particularly thinking about community mental health professionals and commissioners who enable local services to meet the needs of people being discharged from prison or police custody where the rate of apparent suicide is high.

The Panel recently published a new report on suicide prevention, which focusses on people detained in custody. Recommendations to prevent suicide in places of detention, which were informed by PSG members and people with lived experience, were submitted to help shape the recently published National Suicide Prevention Strategy, where people in custody are now featured more prominently.

Last month, we published our report on enhancing the impact of coroners' Prevention of Future Death reports. Panel colleagues and I were pleased to work closely with the Chief Coroner to drive this project forward as well as engage with families bereaved by custody deaths, coroners, and custodial services and agencies to understand their views on how the process should be improved. We have been delighted with the attention the report has received among key stakeholders and in the national press.

In the summer, I visited Brook House, the Immigration Removal Centre at Gatwick and spoke with staff and detainees to better understand the improvements that have been made and the challenges that remain. The IAPDC is working closely with Home Office officials to ensure the recommendations set out in the damming Inquiry Report will be implemented and sustained. I am also keen to talk with Governors across the prison estate so their issues of managing vulnerable people in challenging situations are fully heard and understood.

The Panel is now in the process of deciding its new workplan for next year, and we will provide more information on this in our next newsletter. I want to thank you for all your valuable contributions to help drive forward projects in our previous workplan. I look forward to continuing to work with you. If there is anything you would like to get in touch with us about, then please contact us at iap@justice.gov.uk.

Lynn Emslie
Chair of the Independent Advisory Panel on Deaths in Custody

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ENHANCING THE IMPACT OF CORONERS' PFD REPORTS

Last month, the Panel published its latest report on enhancing the impact of coroners' Prevention of Future Death (PFD) reports to help prevent custody deaths, which received widespread media coverage, including in the Times, Independent, Telegraph, and Express.

As you may already know, PFD reports are issued by coroners to organisations and individuals when they believe action should be taken to prevent future deaths. The Panel consulted with coroners, families bereaved by custody deaths, and services and agencies which respond to PFD reports get their views on how the process might be improved and gather examples of best practice.

It found that several factors are limiting the effectiveness of PFD reports to prevent custody deaths. These relate to the way reports are drafted, published, and distributed, as well as how custodial services and relevant bodies use learning from reports to drive improvements and keep people under the state's care safe.

The Panel makes a series of recommendations to improve PFD processes and practices, which include:

- 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.

The report was also covered by the UK Inquest Law Blog which "widely welcomed" its recommendations. Please do share the report with your contacts and feel free to repost the Panel's link to the report on X (formerly Twitter).

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PREVENTING SUICIDE IN DETENTION

"While we welcome publication of the Government's five-year suicide prevention strategy and the commitment it makes to continue to consider advice from the IAPDC, it must go further and faster to address the desperately high rate of suicide among people under the state's care." - Lynn Emslie

Last November, many of you took part in the Panel's roundtable on preventing suicide across places of detention. You shared your expertise and experiences, concerns and recommendations – all of which were invaluable to informing the Panel's submission to the Department of Health and Social Care to help feed into the new national suicide prevention strategy.

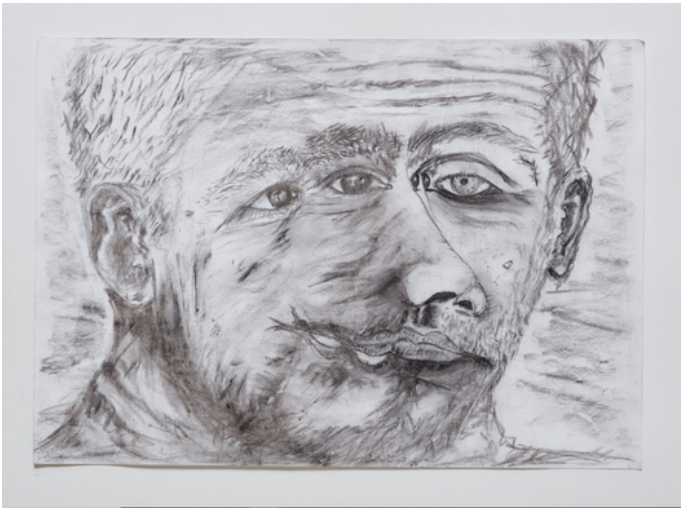

Image courtesy of Koestler Arts.

In February, the Panel submitted a range of recommendations to DHSC on practical ways to prevent suicide in detention, and it continued to engage with officials to help ensure the new strategy covers places of detention properly. Recommendations included equipping staff with tools and confidence to support vulnerable individuals, improving multiagency working and information sharing processes, facilitating meaningful engagement with families, and providing detainees with access to purposeful activities. It also called for an open approach to embedding and sharing learning following a suicide, and greater research in detention settings to inform effective interventions.

The Panel's report was covered in the Guardian. You can read the full report here.

DHSC published its new strategy in September, which the Panel welcomed as a "step in the right direction", but that "greater focus and ambition is needed to prevent suicide in detention". While the new strategy contains sections focused on people in contact with the criminal justice system and mental health services, it has a concerning lack of focus on individuals detained under the Mental Health Act and in police custody. As well as this, it does not feature immigration detention at all, while initiatives set out to prevent suicide in prison do not go beyond existing commitments.

However, the new strategy makes a commitment to "continue to consider advice from the Independent Advisory Panel on Deaths in Custody". The Panel will continue to work with the government, service leaders, and detention staff to ensure its recommendations are put into action to prevent the tragedy of self-inflicted deaths.

You can read the Panel's reaction to the new suicide prevention strategy here.

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PREVENTING POLICE-CONTACT DEATHS

Last month, IAPDC Chair Lynn Emslie and Panel member Raj Desai addressed Police and Crime Commissioners (PCCs) at the **Association of Police and Crime Commissioners**' (APCC) General Meeting in October.

Speaking to APCC Custody Lead Emily Spurrell and PCCs from across England and Wales, Lynn and Raj gave an overview of the Panel's report on preventing policing deaths and the important leadership role PCCs have in preventing these deaths. Discussion included the 'Right Care, Right Person' model, learning from near misses, and the importance of robust scrutiny structures within police forces.

Lynn also gave a presentation on the Panel's policing work at the **National Police Chiefs' Council's (NPCC) National Custody Forum** in September, which was attended by policing stakeholders and senior leaders from across the country to share learning and best practice. Lynn emphasised the importance of collaborative working between different services to ensure people are safeguarded both in police custody and following their release.

Lynn presented the National Custody of the Year 'The Matt Ratana' Award to Inspector Simon O'Neil from Northumbria Police.

Simon has taken a professional interest in the way in which children are dealt with in custody. He has helped to improve children's experiences within custody and assisted officers and staff in dealing with children in their care.

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RAPID REVIEW INTO DATA ON MENTAL HEALTH INPATIENT SAFETY

In June the government published the report of the rapid review into data on mental health inpatient settings, led by Dr Geraldine Strathdee. The Panel had submitted evidence to the review earlier in the year and welcomed the report as an important first step towards improving patient safety.

In its evidence, the Panel highlighted the lack of a single source of reliable, robust, and disaggregated data on deaths under the Mental Health Act – which is key to understanding and preventing deaths of individuals detained under the Act. Dr Strathdee's report raises similar concerns about "fragmented" data collection and the need for improvements to the "timeliness, quality and availability" of data.

However, as the Panel made clear in its evidence, better data alone cannot improve patient safety. An independent body tasked with investigating deaths under the Mental Health Act is vital to ensuring that learning is identified and embedded following a death.

The Panel is keen to work with the government to take forward recommendations from the review to help ensure the tragic deaths of patients detained under the Act are prevented.

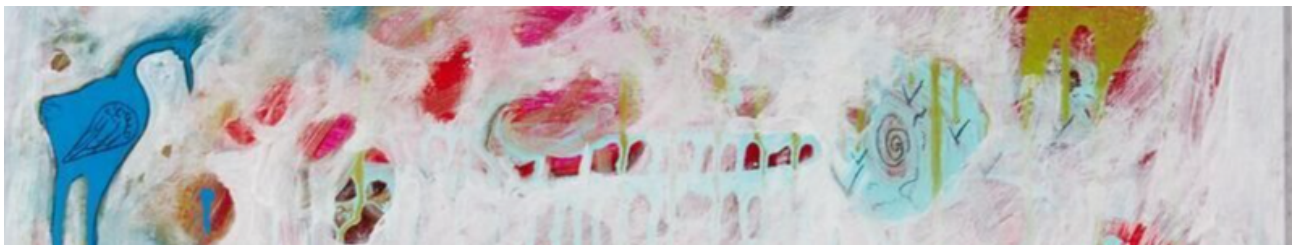

Image courtesy of Koestler Arts.

MINISTERIAL BOARD ON DEATHS IN CUSTODY

In October, Policing Minister Chris Philp MP chaired the latest meeting of the Ministerial Board on Deaths in Custody (MBDC). The MBDC forms one of the three tiers of the Ministerial Council on Deaths in Custody with a membership including Ministers, the IAPDC, scrutiny bodies, and charities.

The meeting included a presentation from the Centre for Mental Health on its prison mental health needs analysis, followed by a presentation from NHSE on its next steps following the report, as well as a presentation on from the NPCC on the new 'Right Care Right Person' model being rolled out across forces in England and Wales to transform the police's involvement in mental health cases. These generated a lot of valuable discussion among Ministers and other Board members.

This was followed by an update from the IAPDC – focusing among other things on the impact of current capacity challenges on deaths in custody risks – and then updates from across prisons, mental health, policing, and immigration detention on current challenges and data on deaths in custody.

You will be able to read the minutes from the meeting once they are uploaded here.

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ENGAGING WITH PARLIAMENT

Last month, the Panel submitted written evidence to the Justice Select Committee's inquiry into the **prison population and estate capacity**. Prison capacity has reached crisis point, with Ministers bringing in emergency measures to provide some relief in the system while plans are underway to create an additional 20,000 new prison places. In its submission, the Panel advised that unless ongoing issues around staffing numbers, the delivery of rehabilitative regimes, and robust healthcare and mental health support are urgently resolved, further expansion of prison places will lead to more prison deaths. You can read the Panel's submission here.

Following the publication of the Independent Office for Police Conduct's (IOPC) latest data on **deaths in and following police custody**, Lynn Emslie wrote to the Policing Minister in August to raise the Panel's concerns about the "alarming increase" in deaths. The IOPC's data show a sharp rise in police deaths, from 11 in 2021/22 to 23 in 2022/23. Sadly, 13 of the 23 people who died had mental health concerns, demonstrating the prevalence of mental ill health in police related deaths.

In her letter, Lynn raised the Panel's concerns about the **National Partnership Agreement** – which seeks to roll out the 'Right Care, Right Person' model across the country – launched in the summer. The Panel has called for a carefully staged approach, with strong safeguards in place, to ensure people experiencing a mental health crisis are not left without vital care and support. You can read the letter here. Lynn subsequently met with the Policing Minister where they discussed these issues and how the Panel can support the government to help prevent police custody deaths.

As you may have seen over the past few months, the Panel has raised several key concerns about the expansion of detention powers under the government's new immigration policies. These concerns were raised by Peers during the Committee Stage of the **Illegal Migration Bill** in the House of Lords in June. Baroness Lister quoted the Panel about the removal of existing restrictions on the detention of vulnerable groups and the risks linked to uncertainty and hopelessness. The Panel's concerns were also raised by Lord German who questioned the suspension of the duty to consult the Independent Family Returns Panel when seeking to remove families. You can watch their contributions here.

Baroness Lister raising the Panel's concerns in the House of Lords

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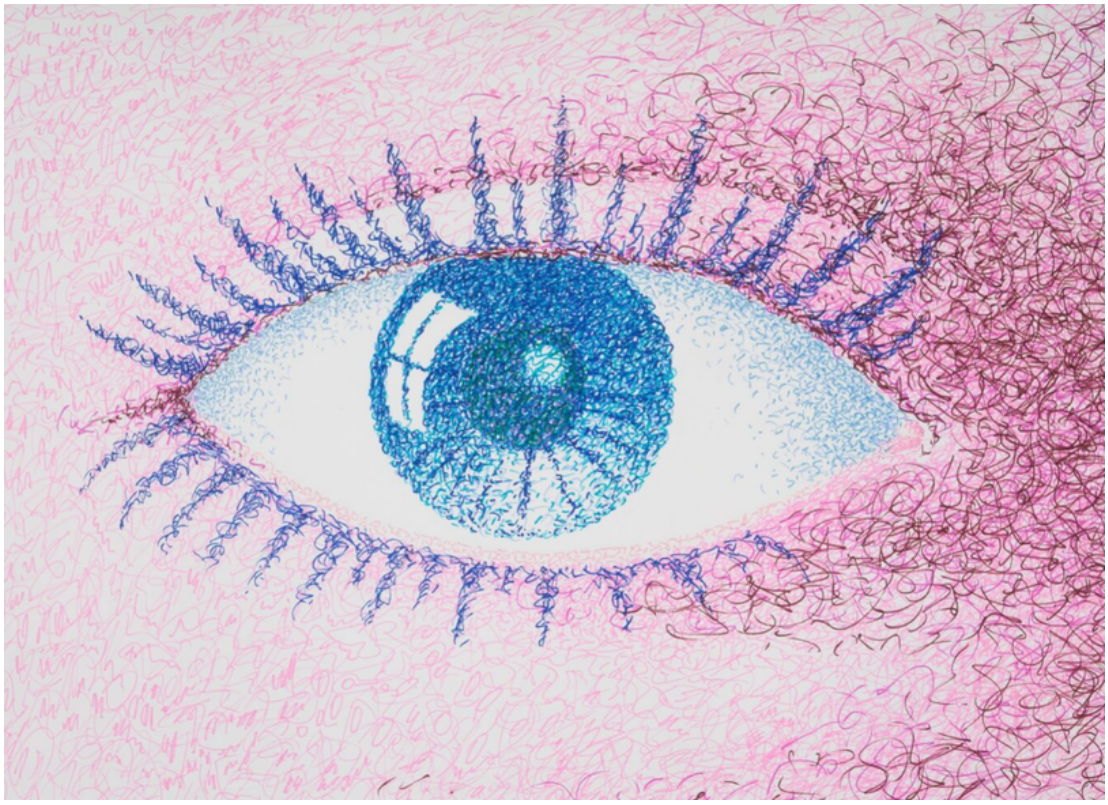
More recently, the Panel received a response from the Immigration Minister to its letter raising concerns about the **Illegal Migration Bill**. The Bill, which has since been passed into law, will see the significant expansion of detention powers. While the Minister seeks to address the Panel's concerns, serious questions remain about how the Home Office will ensure the safety of detainees. The Panel has been engaging with Home Office officials on the Adults at Risk and Rule 35 policies to help ensure they work effectively in practice to identify vulnerabilities and properly safeguard individuals identified as at risk of harm.

In June, the Panel submitted written evidence to the Justice and Home Affairs Committee's inquiry into **community sentences**. In its submission, the Panel focused on the risk to life in prison, with people in prison more likely to die by suicide than people in the community. The Panel called for the prioritisation of alternatives to custody, where appropriate. An example of this is Community Sentences with Treatment Requirements (CSTRs) as an alternative for people with relevant treatment needs. The Panel called for the availability of CSTRs across the country and improved awareness among magistrates about their availability in their court areas. You can read the Panel's evidence here.

FORWARD LOOK

Ministers will be appointing two members to the Panel to join current members Pauline McCabe, Jake Hard, and Raj Desai as well as Chair Lynn Emslie. You can read more about current Panel members here. The Panel will also be putting together a new workplan to outline priority projects to be delivered in 2024. The new workplan will align with priorities of the Ministerial Board on Deaths in Custody.



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IAPDC IN THE MEDIA

Mental Health Cop, 'More than a paper exercise', October 2023

The Standard, 'Coroners' warning loophole branded a 'systemic scandal' amid calls for overhaul', October 2023

The Telegraph, 'Victims forced to wait a decade for compensation from criminals as unpaid fines hit record £1.5bn', October 2023

Independent, 'UK strategy for preventing preventable deaths 'a systematic scandal'', October 2023

The Express, 'Grieving families' plea to stop preventable deaths', October 2023

The Times, 'Families angry that coroners' concerns are being ignored', October 2023

Inside Time,' Influencing the new national suicide prevention strategy', October 2023

The Guardian, 'Staff shortages amid 'deeply worrying' prison deaths in England', September 2023

Pact, 'Pact welcomes new report which aims to reduce suicide in prisons', September 2023

Learning the Lessons, IOPC, 'Tackling obstacles to learning from police-related deaths', August 2023

Inside Time, 'Supporting prisoners and staff', July 2023

Inside Time, 'Jailed for being unwell', June 2023

Inside Time, 'Dying with dignity', May 2023

We are looking for new members to join the Practitioner and Stakeholder Group. We encourage practitioners from a range of organisations, particularly mental health settings, as well as people who have experienced detention and their families to join the group. If you know anyone who would be suitable, please encourage them to join here.