MINISTERIAL BOARD ON DEATHS IN CUSTODY
MINUTES: 9 June 2021, via Microsoft Teams

Attendees:
Parliamentary Under Secretary of State Alex Chalk MP (Ministry of Justice, MoJ) - **CHAIR**
Minster of State Nadine Dorries MP (ND) (Department of Health and Social Care, DHSC)
Minister of State Kit Malthouse MP (KM) (Home Office, HO, and MoJ)

Junior Johnson (JJ), Deputy Director, Scrutiny, Performance and Engagement, MoJ (lead co-sponsor)
Sally Grocott (SG), Deputy Head of Scrutiny, Performance and Engagement, MoJ
Rachel Pascual (RP), Deputy Director, Prison Safety, Security and Operational Policy, MoJ
Kathy Smethurst (KS), Deputy Director, Mental Health and Offender Health, DHSC
Rachael Whittaker (RW), Serious Mental Illness, Legislation and Offender Health Team, DHSC
Heena Mohammed (HM), Deputy Head, Police Powers Unit, HO
Phil Riley (PR), Head of Detention and Escorting Services, Immigration Enforcement, HO
Frances Hardy (FH), Detention and Escorting Services, Immigration Enforcement, HO
Phil Copple (PC), Director General Prisons, HM Prison and Probation Service (HMPPS)
Kate Davies (KD), Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England (NHSE)

Keith Fraser (KF), Chair, Youth Justice Board
Juliet Lyon CBE (JL), Chair, Independent Advisory Panel on Deaths in Custody (IAPDC)
Justin Russell (JR), HM Chief Inspector, HM Inspectorate of Probation
Dr Kevin Cleary (KC), Deputy Chief Inspector of Hospitals and Lead for Mental Health, Care Quality Commission (CQC)
Jonathan Tickner (JT), HM Inspectorate of Prisons (HMIP) *(in place of Charlie Taylor)*
Sue McAllister (SM), Prisons and Probation Ombudsman (PPO)
Dame Anne Owers (AO), National Chair, Independent Monitoring Boards (IMBs)
Michael Lockwood (ML), Director General, Independent Office for Police Conduct (IOPC)
Norma Collicott (NC), HMI Constabulary and Fire Rescue Services *(in place of Tony Hirst)*
Peter Dawson (PD), Director, Prison Reform Trust
Frances Crook (FC), Director, Howard League for Penal Reform
Deborah Coles (DC), Executive Director, INQUEST
Jacqui Morrissey (JM), Assistant Director, Samaritans *(in place of Gareth Germer)*.
Professor Jenny Shaw (JS), IAPDC
Jenny Talbot (JTa), IAPDC
John Wadham (JW), IAPDC
James Parker (JP), Head of Chief Coroner's Office *(in place of Chief Coroner)*
Benedict Philips (BP), Head of Service Programmes, Samaritans *(for item 2)*
Joanna Smith (JS), Operations and Project Volunteer, Samaritans *(for item 2)*

Apologies
ACC Nev Kemp, Police Lead (Custody), National Police Chiefs' Council (NPCC)
Professor Seena Fazel, IAPDC

Sherry Ralph, Acting Chief Executive, Independent Custody Visitors Association (ICVA)
John Thornhill, Chair, Lay Observers' National Council (LO)

Item 1: Welcome, apologies, actions and minutes

1.1 The **CHAIR** welcomed everyone to the meeting including co-chairs Nadine Dorries MP from the Department of Health and Social Care (who would be attending for the first hour) and Kit Malthouse MP from the Home Office. He thanked Frances Crook OBE, attending her final Board meeting, for her valuable insight and input over the years at the Board and elsewhere across criminal justice. Apologies had been received from Nev Kemp and Sherry Ralph.

1.2 Minutes from the last meeting had been approved and circulated and published on the Independent Advisory Panel on Deaths in Custody's (IAPDC's) website.[1] An actions update was also circulated. **THE CHAIR** asked that comments about the minutes or actions be directed to the secretariat.

1.3 The **CHAIR** noted that the numbers of deaths in custody had increased across all custodial sectors over the last year. He outlined intentions for the Board to be ambitious, collaborative and solution-focused.

1.4 The **CHAIR** summarised the objectives of the meeting:

- To agree a revised working model for the Board
- To agree clear next steps for a streamlined and focused workplan
- To examine the latest reporting and updates from departments on work to prevent custody deaths.

Item 2: COVID-19 insights from Samaritan Listeners

2.1 HMPPS have worked with the Samaritans for 30 years to support the Listeners scheme, which has continued during lockdown in prisons. The **CHAIR** introduced the Samaritans to provide insight on the personal challenges faced by people in custody and the implications this has on self-inflicted deaths.

2.2 **BP** explained that Listener schemes work across 137 prisons. There have been variations in the service offered during the pandemic, though 105 schemes were still active, albeit with a reduced number of face-to-face contacts. There had been an increase of over 77,000 prisoner calls (44% rise) this year; social isolation and mental health remained the biggest issues in the male estate while concerns raised in the women's estate were predominantly around violence and abuse. Calls about suicide and self-harm had increased.

2.3 **JS** explained that she had worked for 18 years as a Samaritans volunteer and been part of the Listener scheme for 10 years. She had not been in a prison since March 2020 and the only contact with other Listeners was by telephone. Listeners in prisons were often called out and could only listen at the door to cells, raising worries about

[1] Ministerial Board on Deaths in Custody. Available at https://www.iapondeathsincustody.org/mbdc.

confidentiality. The rollout of in-cell telephony was therefore very welcome. There were concerns that many prisoners were not aware of the scheme.

2.4 In discussion:

- **JT**, **JR** and **PD** raised concerns that Listeners were not being replaced as they were released and that they were under increased pressure and needed support. They suggested there are issues with internet access in older Victorian prisons due to the infrastructure not leading itself to Wi-Fi connectivity.

- **JS** explained that Samaritans were providing support wherever they could, including remotely by telephone and Zoom calls. Many Listeners had expressed concern around the limit to the number of calls they can make to families and have had to turn to Samaritans themselves for support.

2.5 **JM** advised that the Samaritans had recently published a COVID-19 one-year-on report which had a short section on prisons.[2]

2.6 The **CHAIR** thanked the Samaritans for their contributions to the meeting and for the work they were carrying out with prisoners.

Item 3: Discussion of revised working model

3.1 The **CHAIR** explained that member comments from a recent consultation on the Board have been fed into plans for a revised working model.

3.2 **JJ** introduced the revised model. He explained that the new model provides an opportunity to prioritise particular work and new reporting tools (the dashboard) will allow the Board to track progress. The full board will meet twice annually with smaller groups meeting in between where appropriate to take forward priority work. He asked Board members for endorsement of the revised Terms of Reference (ToR) paper.

3.3 In the discussion:

- **FC** said that the purpose of the Board was to hold Ministers to account. While she was content with the revised ToR and focused work, members must still be able to provide challenge.

- **DC** said that NGOs should be able to put forward items for the agenda, and was clear that the Board must not lose sight of the *Angiolini Review into Serious Incidents and Deaths in Police Custody*[3] and necessary reforms to the coronial system. Families should also play a meaningful part in investigation processes.

[2] Samaritans, *One year on: how the coronavirus pandemic has affected wellbeing and suicidality,* June 2021. Available at: https://media.samaritans.org/documents/Samaritans_Covid_1YearOn_Report_2021.pdf.

[3] Dame Elish Angiolini, *Report of the Independent Review into Serious Incidents and Deaths in Custody*, October 2021. Available at: Deaths and serious incidents in police custody - GOV.UK (www.gov.uk).

- The **CHAIR** agreed that the Board should be able to react to short-term issues as well as larger structural ones. **JJ** confirmed that the MoJ would be responding to the Justice Select Committee's report on the Coroner service.

Action 1: Board Terms of Reference to be finalised based on member comments and published.

3.4 **HM** explained the Home Office will be publishing an update on progress against the Angiolini Review before Summer recess and are also committed to holding quarterly meetings with key members to discuss progress going forward.

Action 2: Home Office to establish quarterly update meetings on progress against the recommendations of the Angiolini Review.

DECISION: The Board endorsed the revised Terms of Reference, subject to member comments.

Item 4: Agree priorities and outcomes for MBDC workplan for the coming year

4.1 **JL** reminded members that the new arrangements are subject to annual review and the IAPDC will be more involved in giving expert advice and challenge. Juliet thanked the members for their participation in the consultation and encouraged members to apply high levels of discipline and focus to take forward work on the priority areas.

4.2 **JL** gave an overview of three priority areas proposed by the IAPDC, using input from all Board members gathered through the recent consultation. The recommended priority areas are:

1. Mental Health and substance misuse
2. Embedding learning
3. Physical health and COVID-19

4.3 There will be the aim for each priority area to be informed by the following themes:

a. The evidence base including collation and publication of disaggregated data according to protected characteristics.
b. Race and the impact of disproportionality.
c. The perspectives of – and learning from – people with lived experience and bereaved families.

4.4 In the discussion:

- **FC** agreed with the three priority areas and welcomed the idea of an institutional responsibility to promoting mental health. She said that protecting life was the tenet which needed to run through the whole workplan. JL would discuss looking at the workplan through this lens with the panel at their next meeting.

- **KM** welcomed the attention on mental health, outlining the importance of police officers making an informed assessment of an individual's circumstances when responding to incidents.

- **ND** emphasised the need to separate the issues of 'mental illness' from 'mental wellbeing'. Mental wellbeing references transitionary feelings, such as feeling lonely

on arrival at prison, but is being used as a ‘catch-all’ term which downgrades serious mental ill-health.

- **ML** outlined that police custody officers needed more training and support, and that most of the issues relating to deaths in police custody are caused by fragmented systems, including the levels of support provided by health services for those in mental health crisis.

- **JW** highlighted the need for focus on the period between the point of arrest and release and that issues within the wider system were beyond the remit of the Board.

- **JR** outlined that HMI Probation would be publishing work on the link between mental health and drug use in the autumn. There was a period of high risk immediately following release from custody which the Board’s scope should cover.

- **KM** agreed that there was some work to do to understand risks following release from police custody.

- **SM** stated that the PPO had secured funding to investigate post-release deaths and would be confirming their approach shortly. There were likely to be issues with the notification process which is not yet fully robust. She offered to share learning from this work with the Board.

- **KD** confirmed she was content with the three priority areas and welcomed the overlap of substance misuse and mental health. Evidence showed a whole system approach was needed. However, it was only possible to look at these priorities if there was investment in patients going through the criminal justice system. Investment needed to be made specifically in prisons and other secure environments, not just centrally through the NHS.

- **JM** noted that substance misuse was a high-risk factor for suicide, and welcomed a specific focus on suicide and self-harm. Many people in the system would not have diagnosed mental health problems.

- **JL** made clear that the aim should not be for prisons to serve as psychiatric units. Instead focus should be on transferring those with mental health issues to appropriate care.

- **KM** explained that the Adder project was trying to reduce the supply of drugs so that those with an addiction have less chance of running into a dealer as they leave prison. This was accompanied by a vigorous programme to have settled housing immediately available. He offered to share an update on this work with the Board.

- **DC** confirmed agreement with the three priority areas but added a concern that deaths in secure mental health settings were consistently overlooked by the Board. The figures for deaths in these settings were concerning, and she hoped that the IAPDC could add some much-needed scrutiny. DC added that she had requested at the last meeting that the coroner’s report into the death of Kevin Clarke should be on the agenda for discussion at this meeting. **KM** agreed to have a targeted session on disproportionality.

- **JTa** stated that prisons can cause and exacerbate mental health problems. Wellbeing and mental illness are linked and should not be separated.

4.4 The **CHAIR** asked the co-sponsor leads to briefly outline planned work linked to the three priority areas and highlight areas where input from the wider membership would be valued.

- Secure hospitals: **KS** stated that DHSC were working on a response to the Mental Health Act White Paper (MHAWP) consultation, to which they had received around 2,000 responses. DHSC wanted to build a vision to change the experience of those detained under the MHA and were keen to use the expertise of Board members. Solutions would not simply be focused on legislation.

- Prisons: **JJ** outlined that the MoJ and HMPPS were also working to progress relevant proposals within the MHAWP; monitoring the impact of the latest version of the Assessment, Care in Custody and Teamwork (ACCT) casework management system; developing a new drugs strategy; working with the PPO and HMIP on repeat recommendations; and making reforms to the older prisoners strategy and to compassionate release policy.

- Police custody: **HM** said the Home Office were working with the IOPC on improving data collection; working with the College of Policing to learn lessons from restraint cases; and were interested in advancing work on the number of apparent post-custody suicides.

- Immigration detention: **PR** outlined that the Home Office were progressing the next steps proposed by the IAPDC's 2020 report; working with the prison service on better information exchange; and exploring options for increased Samaritans engagement.

4.5 **KF** noted that children had not been mentioned, though it was important that relevant learning is shared from other sectors with a recognition that children are, and should be, treated differently.

DECISION: The Board agreed to the three proposed priority areas for the following 12 months.

Item 5: Deaths in custody dashboard and key custodial updates

5.1 The **CHAIR** sought views on the new deaths in custody dashboard, requested by Kit Malthouse MP at the last meeting. He outlined that not all statistics in the dashboard covered the same 12-month cycle and that this should be rectified for future meetings.

5.2. In discussion:

- **KM** welcomed the dashboard, especially how it emphasised the need for timely information and learning. He highlighted the PFD concerning the death of Joseph Agnew had only been published in the last six months, years after his death in 2017. He had spoken to the IOPC to see how the Home Office and wider Board could learn faster from incidents.

- **DC** welcomed the dashboard, especially for its use of the names of those who had died, and encouraged all sectors to provide the same level of disaggregated data as offered by HMPPS. She added that a lack of independent investigations continued to be an issue in secure health settings.

- **AO** suggested highlighting the numbers of those who had died while being held under immigration powers in prisons. She raised concerns about short term holding facilities where prescription medication was often taken away from people.
- **ML** welcomed the product and explained that the IOPC's annual deaths during or following police custody statistics would be published in July. The IOPC are working with the Home Office to provide more current information for future Board meetings.

- **JM** requested that self-harm rates be included in the 10-year trend for prisons, as it was a high-risk indicator. She also suggested plotting 10-year trends against other factors such as regime changes. The **CHAIR** and **PC** highlighted some challenges to this approach and suggested it was considered further.

- **JT** asked if deaths taking place within the first 14 days after release from prison could be added to the dashboard if data was available, and if the number could be presented as rates (for instance, per 1,000 in custody) as well as absolute numbers.

Action 3: Secretariat to update dashboard template, taking account of Board Member comments, for future meetings.

5.3 The **CHAIR** invited departmental co-sponsors to give short updates on the data and wider work to prevent deaths in detention.

- Secure hospitals: **KS** advised that a new patient safety incident response framework is being developed to replace the serious incident framework. It is expected to be published in Spring 2022 and fully adopted by Autumn 2022. Data trends in the dashboard referred to deaths from March 2020 to April 2021 due to the CQC's data release cycle. CQC were confident that the increase in deaths is due to COVID-19, though they are still waiting for some final coroner verdicts. Restraint was not used at the time of death in any of these cases. In one case, restraint had been used in the 24 hours prior to death. COVID-19 guidance continues to be updated, and those with serious mental illness are in the priority cohorts for vaccinations.

- Prisons: **PC** summarised the data: there were 408 deaths including 121 from COVID-19 in prison with the significant increase entirely related to COVID-19. There have been fewer natural deaths compared to previous years. A recent Scientific Advisory Group for Emergencies (SAGE) report on *COVID-19 Transmission in Prison Settings* acknowledged that difficult decisions had to be taken in prisons to stop the spread of the virus and this had impacted negatively on sentence progression and wellbeing. Self-inflicted deaths (SIDs) were slightly down on the year before. In 2020 the number and rate of SIDs was lower than the previous seven years, an indication that mitigations were put in place that had a positive impact. The service was making progress on recovery from COVID-19, with all the adult estate at Stage 3 of the National Framework. A few prisons had moved to Stage 2. More than 27,000 prisoners had received the first vaccination dose and 14,000 had received both doses. The new ACCT document started rolling out in the women's estate in April and would be rolled out more widely in future months.

- Police: **HM** summarised that there had been 18 deaths in, or following police custody, during 2019/2020, an increase of one on the previous year. Due to the reporting cycle ending in April 2020, this did not include deaths due to COVID-19. The next annual statistics publication from the IOPC is due in July.

- Immigration detention: **PR** outlined that there has been one death in an Immigration Removal Centre so far in 2021. This was the first self-inflicted death since 2017. Mr

Lavicka had died the night following transfer from prison and his sad death had highlighted issues around information exchange. Immigration Enforcement had given as much emphasis to mental health as to physical health during the pandemic. There had been indications of higher self-harm rates from those that had arrived in small boats.

Item 6: Next steps and AOB

6.1 **JL** raised COVID-19 vaccinations in prison and questioned why a universal vaccination programme had not been applied to prisons, given the evidence outlined in the SAGE report.

6.2 In discussion:

- **PC** stated that rollout was in line with JCVI advice. Deliveries of the Moderna vaccine were now being received for younger cohorts to achieve increased coverage across the whole population. All action taken by the prison service had been in line with JCVI recommendations.

- The **CHAIR** said the Lord Chancellor had recently spoken with Nadhim Zahawi MP, DHSC minister for COVID-19 vaccine deployment. He believed prisons would be experiencing an increase in vaccine supplies soon.

- **KD** said there had been an initial delay in the rollout and that NHS England were doing what they could with limited resources. She had long been an advocate of the whole prison approach. NHSE were prioritising second doses and were working closely with HMPPS to ease logistical challenges.

- **KM** advised that this was a wider issue and that many policing stakeholders were also pushing for priority police officer vaccinations, but that the government had to follow JCVI recommendations.

6.4 The **CHAIR** thanked members for attending. The secretariat will now finalise a 2021/22 workplan based on the discussions at the Board. They will be in touch with Board members to confirm next steps and how the workplan will be monitored and tracked.

Action 4: Secretariat to confirm next steps, and how the Board workplan will be monitored and tracked, with Board members ahead of the next meeting.

Date of next meeting:
30 November 2021 at 12-2pm