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

TWENTY-NINTH MEETING OF THE MINISTERIAL BOARD ON DEATHS IN CUSTODY
MINUTES: 18 November 2020, 2:00pm – 3.30pm, via Microsoft Teams

Attendees:
Minister of State Kit Malthouse MP (Home Office, HO, and Ministry of Justice, MoJ) – **Chair**
Minster of State Nadine Dorries MP (Department of Health and Social Care, DHSC)
Minister of State Lucy Frazer QC MP (Ministry of Justice)

Junior Johnson, Deputy Director, ALB Sponsorship, Strategy, Scrutiny Intelligence and Prison Performance, MoJ (lead co-sponsor)
Sally Grocott, Head of ALB Sponsorship, Strategy, Scrutiny Intelligence and Prison Performance, MoJ
Rachel Pascual, Deputy Director, Prison Safety, Security and Operational Policy, MoJ
Kathy Smethurst, Deputy Director, Mental Health and Offender Health, DHSC
Rachael Whittaker, Serious Mental Illness, Legislation and Offender Health Team, DHSC
Heena Mohammed, Deputy Head, Police Powers Unit, HO
Samantha Newsham, Head of Core Police Powers, HO
Craig Spencer, Police Powers Unit, HO
Phil Riley, Head of Detention and Escorting Services, Immigration Enforcement, HO
Frances Hardy, Detention and Escorting Services, Immigration Enforcement, HO
Phil Copple, Director General Prisons, HM Prison and Probation Service (HMPPS)
Kate Davies, Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England (NHSE)
Fiona Grossick, National Clinical Quality Lead, NHSE

Keith Fraser, Chair, Youth Justice Board
ACC Nev Kemp, Police Lead (Custody), National Police Chiefs' Council (NPCC)
Juliet Lyon CBE, Chair, Independent Advisory Panel on Deaths in Custody (IAP)
Charlie Taylor, HM Chief Inspector**,** HM Inspectorate of Prisons (HMIP)
Sue McAllister, Prisons and Probation Ombudsman (PPO)
Dame Anne Owers, National Chair, Independent Monitoring Boards (IMB)
Michael Lockwood, Director General, Independent Office for Police Conduct (IOPC)
Tony Hirst, Deputy Director, Joint Criminal Justice Inspections, HMI Constabulary and Fire Rescue Services *(in place of Wendy Williams)*
HHJ Mark Lucraft QC, Chief Coroner of England and Wales
Katie Kempen, Chief Executive, Independent Custody Visitors Association (ICVA)
John Thornhill, Chair, Lay Observers' National Council (LO)
Peter Dawson, Director, Prison Reform Trust
Frances Crook, Director, Howard League for Penal Reform
Deborah Coles, Executive Director, INQUEST
Jacqui Morrissey, Assistant Director, Samaritans *(in place of Gareth Germer)*.
Jenny Shaw, Independent Advisory Panel on Deaths in Custody
Jenny Talbot, Independent Advisory Panel on Deaths in Custody
John Wadham, Independent Advisory Panel on Deaths in Custody

Apologies
Justin Russell, HM Chief Inspector, HM Inspectorate of Probation
Dr Kevin Cleary, Deputy Chief Inspector of Hospitals and Lead for Mental Health, Care Quality Commission (CQC)
Seena Fazel, Independent Advisory Panel on Deaths in Custody

Item 1: Welcome, apologies and future Board priorities update

1.1 The Chair welcomed everyone to the meeting, including his co-chairs Nadine Dorries MP from the Department of Health and Social Care, Lucy Frazer QC MP from the Ministry of Justice, and Charlie Taylor, the new HM Chief Inspector of Prisons.

1.2 Minutes from the two COVID-19 sub-meetings in July and actions from previous meetings had been circulated. The Chair suggested any amendments or questions on these should be directed to the secretariat. Katie Kempen, ICVA, asked for a correction to be made to previous minutes.

1.3 The Chair emphasised that each death in custody was a catastrophe for the organisation, the individual, the family and for the community and he asked that everyone keep this at the forefront of their minds. He emphasised that the ideal target number for state custody deaths is zero. Central to driving down the numbers of deaths was ensuring Ministerial Board works effectively.

1.4 The Chair handed over to Junior Johnson, lead co-sponsor from the MoJ, to talk about plans for the future of the Board. Junior explained that this was the first full meeting of the Ministerial Board since July 2019. Everyone agreed about the importance of reducing state custody deaths, but the COVID-19 pandemic had brought this priority into renewed focus. The Board now needed to develop a new workplan for 2021. This may involve reforms to the frequency and structures of the meetings. The team will be taking comments from members on how to do this in the coming weeks and months.

1.5 The Chair was keen for departments and agencies to use the Board as a mechanism to share and learn from each other. He expressed a frustration around the delay between a death taking place and practices changing on the frontline. He suggested a standing item at the Board that looks at the current picture covering what has happened in the last six months to determine what patterns may exist. A new dashboard could include the number of incidents, how deaths occurred, and a summary of measures in place to prevent reoccurrence.

Action 1: All custodial sectors to scope out and contribute to a central dashboard, owned by the secretariat, setting out the latest data and key information concerning state custody deaths.

1.6 Deborah Coles referenced repeat conversations at the Board, identifying Coroners' Prevention of Deaths reports (PFDs) as a case in point. She said she

had presented a paper in 2010 on lack of cross-sector learning and preventative potential of Rule 43 reports (now PFDs). Deborah suggested a review of the recommendations made to the Board already to see what progress had been made. She was also concerned that Ministers and others forgot that the deceased were real people. The Chair agreed strongly that knowing names was important and humanising the discussion could help learning.

1.7 Michael Lockwood argued that focus should be on prevention rather than response, and asked for assurances that work was taking place on the ground. Juliet Lyon stated that she would welcome a Board that was determined to achieve, was mutually accountable, and could progress work between meetings.

1.8 Minister Frazer said that she welcomed any reforms that would make the Board more effective. She said that rather than lots of streams of work, the Board should focus on a specific number of tangible objectives and she asked members for their comments and suggestions. Minister Dorries agreed that the Board should identify specific areas of focus with recommendations themed where possible. She said her department wanted to learn from past mistakes so that they do not recur. The Chair stated that the Board should be holding ministers and officials to account and that departments needed to be clear about what was and was not possible to deliver.

Item 2: Coroners' Prevention of Future Deaths reports

2.1 The Chair explained that for today's discussion each department had been asked to set-out the process by which they received and acted on a Prevention of Future Deaths reports issued by coroners. He invited co-sponsors to share their key findings.

<u>Police custody</u>

2.2 Heena Mohammed, HO, explained that in 2020 the Home Office had received 5 PFDs and the NPCC 7 PFDs since September 2018. The themes raised were familiar ones: mental health, use of force, and training. Next steps referenced included:

- the College of Policing (CoP) with Nottingham University were launching a toolkit for forces to use to undertake evaluations of their street triage schemes;
- there was now full coverage of Liaison and Diversion services across England;
- CoP had produced guidance on suicide prevention;
- a new Code of Practice for Armed Policing and Police Use of Less Lethal Weapons made clear that all new less lethal weapons systems require approval by the Home Office before they can be used by police forces; and
  revised guidance on de-escalation guidelines was recently published.

2.3 Heena stated that there was more that could be done to improve the Home Office's own internal processes around the use of PFDs and that the exercise had been helpful to realise this. She explained that the Home Office did not receive PFD reports (as they went directly to the police force) but felt that it would be helpful to receive them so that they could be addressed thematically and

strategically. She suggested PFDs should also be shared with the National Police Chiefs' Council, the Independent Office for Police Conduct and the College of Policing.

Prison custody

2.4 Phil Copple explained that themes identified were familiar and reinforced evidence found in HMPPS' own audits and in the Prisons and Probation Ombudsman investigations. HMPPS had well established procedures to disseminate recommendations to the front line. The learning from reports was also shared with prison safety leads across England and Wales. Issues that emerged from the analysis were reflected in work under way, including the revised ACCT process and staff training. The challenge remained, however, of how to improve practice and ensure compliance across the thousands of staff on the frontline.

Immigration detention

2.5 Phil Riley explained that deaths in immigration detention were very rare. This did not lessen the impact but did make organisational learning more difficult especially in cases where there was a long delay between a death and the subsequent inquest. Immigration Enforcement had received eight PFDs in 10 years. He stated that compliance was difficult to ensure as Immigration Enforcement did not manage the establishments. However, the exercise had demonstrated ways that the service could work more closely with NHS England, health providers and HMPPS.

Secure mental health services

2.6 Kathy Smethurst explained that many of the themes raised through analysed PFDs concerned how to respond to individuals in a mental health crisis. NHS England and NHS Improvement (NHSE/I) and CQC had processes in place to respond to PFD recommendations, though they could do more to join up with other sectors. NHSE/I were taking stock of processes and a working group was considering how best to respond to PFDs.

2.7 The Chair asked Board members to consider a number of questions:

- Which organisations receive and act upon these reports? Are these the right organisations?
- What role can the Board (and its secretariat support) play in analysing and disseminating these reports to ensure lessons are learned?
- Are issues of concern being adequately addressed and learned from? Are the actions described by the departments delivering the outcomes Board members expect to see?
- How would Board members like to be kept informed on this ongoing analysis?

2.8 The Chief Coroner said that he had reissued guidance to coroners about completing PFD reports and this would be followed up with training with the key message to bring a consistent approach to writing and formatting the reports. All PFD reports were published on the Chief Coroner's website, and the names of the deceased were published in the text (though some other personal data was redacted). Responses from recipients were also uploaded to website, though the Chief Coroner noted that these were not always timely and the deadline of 56 days was often missed. He reflected that responses were also often too lengthy and

unfocused. The Chief Coroner was not in favour of his office copying the reports widely, as they were on his website which all departments and agencies had access to. His team were working on making the reports more easily accessible. He was encouraged that this was a key area that the Board wanted to address, as the coroner's responsibility in law ceases upon issuing the PFD. The Chief Coroner suggested that departments should find ways of triaging received reports within their own organisations. The Chair agreed with this suggestion.

2.9 The Chair suggested a central analysis be presented to the next Board illustrating how many reports had been published during recent months.

Action 2: Secretariat to scope out and provide an analysis of recent PFD reports in collaboration with all custodial settings to identify recurring themes to be shared with Board members going forward.

2.10 Frances Crook was sceptical about action taking place and referenced the key-worker initiative in prisons as an example. She was not convinced that this had been rolled-out across the estate or that there were high-quality conversations taking place between staff and prisoners, which she felt were vital during the significant lock-up prompted by COVID-19 response measures.

2.11 Deborah Coles emphasised that better systems were needed. She referenced the Linden Centre in Essex where seven mental health patients had died. Recommendations were not followed and more people subsequently lost their lives. INQUEST often saw responses from custodial sectors that read like they were cut-and-pasted from guidance and policy reports. More needed to be done to look at how organisations learn to create opportunities for organisations to come together to learn. The Angiolini Review had recommended a 'national oversight mechanism' that could be a repository of these reports and conduct cross-government analysis.

2.12 John Wadham stated that it was not currently clear who was responsible for ensuring that lessons were learned. The Chair replied that while Ministers were accountable, many organisations, such as police forces, were independent so much relied on the cooperation of others. His levers to effect change were limited and there were others, such as Police and Crime Commissioners, who were democratically elected and also had authority over police forces.

2.13 Minister Dorries referenced the Healthcare Safety Investigation Branch, based on an airline industry model, which carries out investigations within a 'no blame' culture, and wondered if anything could be learned and applied to custodial settings. She suggested the Board could look at how HSIB operated and how its principles were applied.

Action 3: DHSC to consider the Healthcare Safety Investigation Branch principles and how learning from these cases could be applied to deaths in custody.

2.14 Minister Frazer agreed that as a Minister she was accountable. She said that HMPPS had a large number of people working to ensure that establishments were safe and recommendations examined and implemented. The Minister suggested

good work was being carried out and anecdotal stories were overshadowing what was happening across the service. Phil Copple confirmed that the keyworker scheme was rolled out to all closed prisons for men before COVID-19, but that there was work to be done to ensure that it was fully embedded everywhere. The service still had plans for moving ahead in open prisons and the women's estate. He suggested it was important to acknowledge the level of disruption caused by the virus and to recognise areas where the system had worked effectively. For example, there had been fewer self-inflicted deaths in the last few months. Disruption had also delayed the inception of the planned High Reliability Project, an approach developed in high-risk environments which HMPPS is seeking to learn from and apply in prisons. He shared the ambition to eradicate repeat recommendations.

2.15 Sue McAllister suggested that processes were in place theoretically (for instance, key workers) but that did not guarantee that the quality of contact with prisoners was good. She argued that there was a gap between the culture and practice on the ground.

2.16 Michael Lockwood stated that bereaved families wanted accountability but, more so, they wanted the experience to not happen to anyone else. The IOPC had Section 28 powers but could also issue Section 10 recommendations for quick-time responses in circumstances of immediate concern. IOPC circulate publications to police forces with practical examples which can save lives. He explained the importance of near miss cases and referenced a case where a detachable chord had been used as a ligature which once identified prompted learning to be shared and changes made as a result. Within forces, good leadership and culture prompted change. Horizontal learning between forces was not good enough. He felt training was seen as a cost rather than an investment and there was a deficiency of training in police custody suites. For example, training on verbal de-escalation techniques should be expanded. Learning happened at inquests, although he believed this was an unequal system where families were not supported through adequate legal aid funding.

2.17 Charlie Taylor said that processes and procedures were needed to prevent tragedy, but mindset, culture and a safeguarding mentality were also important.

2.18 Deborah Coles suggested revisiting the conversation about how to engage bereaved families on what action had been taken after a death. She also highlighted issues about the conduct of state lawyers at inquests, particularly in arguing against the making of PFDs. Ministers needed to address this as it undermined the outcome of an inquest. Deborah also expressed concern about the high number of deaths in mental health institutions and NHS Trusts. She said there were no independent mechanisms of investigation and no thematic assessment of what came out of inquests.

2.19 The chair summarised the item; he agreed that reports should be central to the Board's work going forward; that the Board should develop an information tool to look at the full picture; and that members should challenge ministers about the implementation of recommendations.

Item 3: Custodial updates

3.1 The Chair explained that he had recently met with Dame Elish Angiolini and other key stakeholders to discuss the Angiolini Review. He asked custodial leads to give a summary of the update papers they had submitted to the Board.

Police custody

3.2 Heena Mohammed stated that since 2017 the Ministerial Board had been largely structured around the thematic recommendations of the Angiolini Review. Many of the recommendations had been completed, including updated NPCC and College of Policing guidance on use of restraint and improved support and information for families following a death in custody. There was more still to be done and the Home Office would produce a full written update on progress against the Review early next year. They will also bring a paper to the next meeting on the recommendations to give further detail. Michael Lockwood summarised that the recently published IOPC deaths statistics were similar to previous years and raised similar themes such as mental health.

Action 4: Home Office to publish official update on the Angiolini review and share with Board members.

Secure mental health services

3.3 Kathy Smethurst stated that CQC had been publishing data on COVID-19 and non-COVID-19 related deaths among people detained under the Mental Health Act. Work had been done during and learning from the first wave of the pandemic, including on infection control, access to therapeutic support, specific guidance on appropriate application of the legal frameworks around isolation and testing during the pandemic. Members of the IAP met with the NHS team leading on secure mental health services who shared insight from the experiences of those in secure mental health settings, captured through the recent Rethink report '*Adult Secure Service User, Family and Carer Feedback Survey during the Coronavirus (Covid-19) pandemic'*. The guidance now in place would help to support people through the second wave.

Prisons

3.4 Phil Copple explained that the latest data on deaths and self-harm was published at the end of October. HMPPS had expected to see an increase in the number of deaths during the pandemic, with the original modelling for the reasonable worst case scenario suggesting 2700 deaths in the first wave. In fact, there had been 27 deaths in the first wave, but HMPPS had now started to see further deaths in the second wave. There had been a reduction in the number of self-inflicted deaths since the previous year and the rate was lower than the previous two years despite the greater challenges, which reflected good work by staff to support the people in their care.

3.5 Phil reported that the requirement to report an instance of noose-making as an incident of self-harm was withdrawn in April 2020 and concerns had been raised by Board members about this decision. He apologised for not communicating the change but reassured members that incidents in which a noose had been used as a ligature continued to be reportable as self-harm. He acknowledged the concerns

about operational practice and would write to governors about the seriousness of noose making.

3.6 In the follow-up comments, Dame Anne Owers expressed her concern about the lack of communication on the noose-making issue, which had been signed off by ministers. She would have expected the IAP at least to have been consulted. She was worried that it may signal to the frontline a lessening of the importance of the issue. Phil said he understood the concerns but emphasised that the change was only to the reporting process and he was confident that there would be no change to the operational response in such cases. He explained that other instances of behaviour that may be preparatory for self-harm, such as stockpiling medication or extracting blades from razors, were not reportable, and that this is complex territory, because each of these behaviours can also serve other purposes. He committed to explore the introduction of a separate category to capture incidents of "preparation for self-harm".

Action 5: HMPPS to explore the introduction of a separate incident category of "preparation for self-harm".

Immigration Detention

3.7 There had been no deaths in the immigration detention estates during 2020. Phil Riley reported that centres had escaped the worst of the pandemic, with only six cases in the second wave. He described the two-stage contact for liaison with bereaved families – an initial letter of condolence with a further letter setting out learning points post-inquest. Immigration Enforcement had also updated their guidance leaflet for bereaved families. He recognised that those in immigration detention have particular vulnerabilities which are different to prisoners and it was important to learn from those establishments. IAP had carried out a review for Immigration Enforcement on the deaths in detention recommendations from the Stephen Shaw review of welfare in detention of vulnerable people, which they had presented to the Immigration Detention Reform Board recently.

Item 4: AOB

4.1 Deborah Coles suggested that the outcome of the inquest into the death of Kevin Clarke in police custody in 2018 should be discussed at a future meeting as it cut across healthcare services, policing and justice.

4.2 The Chief Coroner said that he had engaged with Dame Elish Angiolini about her review recommendations. He was working on a toolkit for advocacy at all inquests. He indicated that his term as Chief Coroner was coming to an end and he would ensure that his successor continued to attend the Board.

4.3 Kate Davies asked that the Board retain focus on substance-related deaths.

4.4 The Chair said that there will be lots of work to do in the coming months in preparation for the next meeting. He thanked everyone for attending and for their contributions to the discussions.