Independent Advisory Panel on Deaths in Custody
Minutes of IAP meeting – 21 October 2020

Attendees:
Juliet Lyon - Chair
John Wadham
Deborah Coles
Jenny Shaw
Seena Fazel
Kish Hyde
Piers Barber
Graham Randall

Apologies:
Adrian Blake
Jenny Talbot

Item 1: Discussion with Alexia Durran, Deputy Chief Coroner

1. Juliet welcomed Alexia Durran, Deputy Chief Coroner, and Anne-Marie Aherne, Chief Coroner's Office, to the meeting.

2. Alexia explained how an analysis of emerging themes from Preventing Future Deaths (PFDs) reports over the last 18 months had been conducted and that the Chief Coroner will shortly be publishing updated guidance for coroners on how to compile them. She outlined that the Coroner has no sanctions or powers following an inquest to chase up on recommendations and that this was an on-going concern. Her team are updating the Chief Coroner/PFD website to make it more user friendly and make searching easier. As outlined in her Keeping Safe presentation, Alexia wants PFD reports on deaths in custody to be copied to IAP.

3. Deborah agreed that there was an accountability gap. For example, the Chief Inspector of Prisons' new Annual Report showed that Prisons and Probation Ombudsman recommendations had a low 40% response rate from prisons. The Angiolini Review had recommended a national oversight body that could follow up and ensure lessons were taken on board. Deborah stated that PFD reports should go to the IAP, the chief inspector and any other relevant agency.

4. Alexia agreed that PFD reports were under-utilised as a learning tool. New coroners' training has helped and the new guidance has a template to help focus the content of the PFD. She agreed that responses to recommendations are often

bureaucratic and some coroners have stated that they are not useful. Alexia reiterated that the coroner's work and authority is concluded upon finalising the draft of the report; the coroner has no power to pursue recommendations but there should be some way of sharing lessons from reports.

5. Juliet explained that this will be a substantive item at the next Ministerial Board on Deaths in Custody and that she would like to have a series of steps prepared and to give a steer to Ministers in advance of the Board.

6. Jenny S remarked on the need to be aware of both local level and national level issues arising from recommendations; the key challenge is getting these to the frontline staff possibly via checklists or regular learning sessions. Alexia agreed and was especially interested in this as the Coroners' Society had previously written to bodies on this subject. The Society and the GMC want to disseminate learning through their professional bodies networks.

7. Deborah felt that the new guidance would be really useful, as not all coroners were aware of who the reports could be directed to and sometimes coroners were dissuaded from writing reports altogether by organisations who said that they had already put measures in place since the death. She also noted that early reports used to have a thematic analysis.

8. John suggested that there should be a mechanism in place for the Chief or Deputy Chief Coroners to meet leaders of places of state detention/heads of services to follow-up on actions; Alexia thought this might be worth considering and Juliet thought the IAP could convene these discussions if useful. An annual meeting could consider main themes emerging from PFDs.

9. Seena asked if there was any learning between coroners in Northern Ireland and England. Anne-Marie stated there was much shared knowledge between coroners, and that they are in regular touch with Northern Ireland to share knowledge and advice.

10. Alexia welcomed the new Sentencing Council guidelines on sentencing vulnerable people.

Action 1: Juliet and Panel to put ideas for closer collaboration to Chief Coroner's Office.

<u>Item 2: Minutes and actions from last meeting</u>

11. Juliet introduced Graham to the panel and welcomed him to the team.

12. Juliet drew attention to the following outstanding actions:

    - *Seena to share any relevant literature on the link between data and digital delivery with DHSC*.

Seena is finalising an email with relevant material.

- *Secretariat to arrange meeting with Claire Murdoch, national director for mental health, NHS, to identify areas for IAP support including consulting on detained patient/service user experience*

Piers has contacted Louise Davies and Kathy Edwards about a potential IAP exercise to gather user experience in inpatient settings. Secretariat will continue to seek to build links with DHSC/NHS.

Jenny S and Seena to consider relevant research for inclusion on the new Learning Library section of the IAP website.

Juliet asked Jenny and Seena, and the rest of the panel, to forward any information for the Library, which will be developed upon Adrian's return.

- *Panel members to give feedback and updates on workplan tracker before the next meeting*

JL encouraged everyone to have a close look at the tracker.

13. John asked whether the workplan was too long and if the panel were taking on too much; a lot of time was spent at each meeting on reporting back to the detriment of more strategic discussions. Juliet said that the panel-only sessions were useful places to have these discussions.

Item 3: Policing next steps:

Kevin Clarke Inquest

14. Deborah summarised the inquest's jury narrative. The coroner also presided over the Sean Rigg inquest, which prompted the Angiolini Review, and the concerns arising from both deaths were similar. The issues were not a question of training or guidance as all of these were in place, but about the assumptions made about Kevin Clarke as a BAME male rather than concern shown for his mental health. Funding for mental health services is key. The PFD will be available in a few weeks. Deborah expressed frustration about not being able to track what work had been conducted since Sean Rigg's death.

15. Jenny S said that there seemed to be no guidance or clarification for police officers on when they should call out street triage/emergency medical experts, and that anecdotal evidence suggests availability is variable across the country.

Action 2: Secretariat to obtain greater detail about street triage evaluation conducted by the College of Policing in collaboration with Nottingham University.

16. Juliet had a useful meeting with Minister Kit Malthouse who is committed to preventing deaths and working with both the Ministerial Board and the IAP to drive down the numbers of deaths in police custody. They discussed joint communications from the Minister and the IAP to relevant leaders/organisations, including police chiefs, police and crime commissioners, the College of Policing and the Police Federation, to establish that no death in custody is acceptable.

Juliet suggested that the panel develop a practical plan for preventing deaths then meet the Minister as a panel before Christmas to discuss further action.

17. The Minister was mindful of the impact on families and had asked Juliet if he should write to Kevin Clarke's family. He referred to the Harris recommendation that the Minister ring bereaved families personally following a death. Juliet was aware that the Minister does not have full control over police to drive actions but does have influence to change culture.

18. Seena said there was a need for further research studies related to street triage; Jenny S would be willing to work together on this, which would be more of a priority for funding than more prison prevalence studies.

19. Deborah asked what practical measures the Minister was willing to take. She believed the feedback from officials on progress made on the Angiolini Review to Dame Elish overstated what action had actually taken place. Any letter from Kit Malthouse MP needed to be focussed on actual action. Juliet suggested the IAP have a mapping exercise to work out exactly what they want to say to Minister before any IAP advice is finalised.

Action 3 – Juliet and panel to prepare advice for Kit Malthouse before the Ministerial Board suggesting steps leaders and organisations can take to drive down numbers and prevent deaths in custody.

Item 4: Drug-related deaths project next steps

20. Juliet had a meeting with Jane Trigg, HMPPS Head of Drug Strategy Development, who is interested in having a roundtable event on this issue. Jenny S to have further discussion with Jane

20. Juliet referred to Peter Clarke's recent media interviews as the outgoing HM Chief Inspector of Prisons and the link to the IAP's discussions about drug related deaths. Jane had stated that these deaths have not fallen since the start of lockdown so there is an ongoing problem with how drugs are brought in to establishments. Juliet suggested forging a closer working relationship with the next HMCIP.

Next meeting:

3 November 11am-12.30pm.

Co-sponsors attending 11.30am-12.30pm

Summary of actions:

- **Juliet and Panel to put ideas for closer collaboration to Chief Coroners' Office.**
- **Secretariat to obtain greater detail about street triage evaluation conducted by the College of Policing in collaboration with Nottingham University**

- **Juliet and panel to prepare advice to Kit Malthouse before the Ministerial Board suggesting practical steps organisations can take to drive down numbers and prevent deaths in custody**