Independent Advisory Panel on Deaths in Custody

Mid Term Progress Report on the Work of the IAP and Future Priorities for the Work of the Panel

February 2011

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Foreword by Lord Toby Harris, Chair of the Independent Advisory Panel (IAP) on Deaths in Custody

This report provides details on the progress the IAP have made since our creation in April 2009. Ministers appointed me as the inaugural Chair of the IAP in December 2008. This was followed by the appointment of six independent Panel members in April 2009, who were selected for their expertise in matters connected with deaths in custody. We have now been in operation for 18 months and I believe this provides us with an ideal opportunity to reflect on what we have achieved during that time and what we plan to take forward over the next twelve months.

A death in custody is a uniquely serious and irremediable event particularly so as the state has a special duty of care towards those in custody, which is enshrined in Article 2 of the European Convention on Human Rights (ECHR). As well as the financial implications of such deaths, there are also enormous emotional costs for the families and staff affected. In order to try to prevent these deaths in the future, it is imperative that we ensure that any lessons are effectively shared across all custodial sectors. The Fulton Review[1], called for the establishment of the Ministerial Council on Deaths in Custody in order to bring about a reduction in the number and rate of deaths in all forms of state custody and strengthen the procedures for sharing learning. This covers deaths, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital.

The IAP forms one tier of the three tier Ministerial Council on Deaths in Custody, the creation of which was announced by the Ministry of Justice in July 2008 following publication of the Fulton Review. The role of the IAP is to provide independent advice and expertise to the Ministerial Board on Deaths in Custody, which forms the first tier of the Council in order to help shape government policy in this area. The Panel is supported by a Practitioner and Stakeholder Group, which provides expertise and input into our work.

The work of the IAP is primarily being taken forward by six working groups, each led by a member of the Panel. These are considering the issues of the use of physical restraint, cross sector learning, information flow through the criminal justice system,

[1] You can view the full report by visiting: http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2010/02/The-Fulton-Report-2008.pdf

the deaths of patients detained under the Mental Health Act (MHA), Article 2 compliant investigations and the risks relating to the transfer and escorting of detainees. The working groups on the use of restraint and cross sector learning made a series of recommendations to the Ministerial Board in 2010, which were endorsed by Board members and these are covered in section 3 of the report. The four remaining working groups will present their findings and recommendations to the Board in 2011.

Since April 2009, the IAP has held eight Panel meetings, which allow us to monitor the progress of our work programme and ensure that we take account of any emerging issues that have relevance for our work. In order to ensure our work is as informed as possible, the Panel were keen to undertake a number of visits to custodial establishments to gain an understanding of the range of issues faced by operational staff when dealing with a death in custody. In November 2009, we visited Broadmoor Hospital to observe the workings of a high secure hospital first hand and discuss with staff appropriate measures for the prevention of suicide and other deaths. The Panel also met with senior clinical members of staff and learnt about some of the practical problems associated with the identification and reduction of risk for patients detained under the Mental Health Act (MHA). A second visit to Ealing Approved Premises was undertaken in December 2009, which allowed Panel members to see how learning had been identified and used to inform practice and policy within this setting. These visits were of enormous benefit to the IAP and similar visits will be undertaken over the next twelve months.

In order to inform the direction of the Panel's six working groups, a series of meetings with key stakeholders have been held, which have been helpful in bringing together organisations that had not previously engaged in discussions, despite having a shared interest in reducing deaths in custody. The IAP family listening day, which was held in conjunction with INQUEST in March 2010, was a great success. Discussions from the day helped Panel members understand the experiences faced by families when encountering the inquest and investigation process and the families' impressions of the way their cases were managed by the state. In May 2010, a cross sector restraint workshop was held, which brought together representatives from the various custody sectors to discuss common issues around the use of physical restraint and share examples of best practice and learning. Both of these events generated very useful reports, which included a series of

recommendations to address identified gaps, which were met with broad support by members of the Ministerial Board.

The events and range of meetings held by the IAP have provided stakeholders with an excellent opportunity to share best practice and learning. They have also been crucial in helping to shape the work of the IAP and both the Panel and I are grateful to all those that have participated in these over the last eighteen months. We are keen to build on these valuable consultations and plan to hold two further events in 2011, a family listening event with family members affected by the death of a relative whilst detained under the MHA and the first IAP national stakeholder consultation event. Both of these events are covered in more detail in section 3 of this report.

We recognise that there is more hard work to be done over the next year and look forward to continuing to work with members of the Ministerial Board and Practitioner and Stakeholder Group to strive to bring about a reduction in the number of deaths in state custody and share learning and information about means of preventing deaths in custody. This report details the progress we have made so far and what we are aiming to achieve in the future.

Finally, I would like to offer my thanks on behalf of the Panel to the Secretariat team for their hard work and support over the last two years.

Thank you for taking the time to read this report and I hope you find it informative. If you have any comments or questions about the contents, please feel free to contact the IAP via the contact page on our website.

Members of the Independent Advisory Panel (IAP) on Deaths in Custody

Simon Armson is currently a clinical psychotherapist, a Mental Health Act Commissioner and a Member of the Mental Health Review Tribunal. He chaired the Mental Health Act Commission for a period in 2008/09. From 1989 to 2004, he was Chief Executive of the Samaritans, having worked as a Samaritan volunteer for 31 years, and was instrumental in developing that organisation's work in prisons. He has a particular interest in mental health and suicide prevention.

Deborah Coles is Co-director of INQUEST. She has experience of individual casework on deaths in custody across the criminal justice system with particular emphasis on the interests of bereaved families. She has a long-standing interest in cross-sector learning. Deborah undertakes policy, research and campaigning work on the strategic issues raised by contentious deaths, their investigation, the treatment of bereaved people and state accountability.

Peter Dean is an experienced coroner in Suffolk and Essex and a Forensic Medical Examiner with the MPS, with a background in general practice. He has knowledge and experience of deaths in police and prison custody and has provided advice, guidance and training to police custody staff for some years.

Philip Leach is a Professor of Human Rights at London Metropolitan University and a former Legal Director of Liberty having originally trained as a solicitor. He has undertaken training in human rights for prosecutors, police and judges and been involved in casework with prisoners both in the UK and abroad.

Richard Shepherd is Consultant Forensic Pathologist at St George's Hospital London and the Royal Liverpool Hospital. He is a registered Home Office Forensic Pathologist and a leading forensic pathologist in the field of deaths during restraint, with experience of deaths in all forms of custody, including natural, suicidal and homicidal causes. He is also a member of the Criminal Injuries Compensation Appeals Panel.

Stephen Shute is Head of the School of Law, Politics and Sociology at the University of Sussex. He is a leading academic in the field of criminal law and criminal justice, in particular on prison issues but also undertaking recent research into ethnic minorities in the criminal courts. He is currently a member of the Advisory Board on Joint Inspection in the Criminal Justice System and the Management Board of the CPS Inspectorate.

Section 1: Background to the Ministerial Council on Deaths in Custody

The three tier Ministerial Council on Deaths in Custody officially commenced operation on the 1st April 2009 and is jointly funded by the Ministry of Justice, Department of Health and the Home Office. The Council will operate initially for a period of three years, after which time a review will be undertaken to determine the effectiveness of these arrangements.

The first tier of the Council consists of a Ministerial Board on Deaths in Custody, which has replaced the Ministerial Roundtable on Suicide and has wider terms of reference to include all types of death in state custody. The Board has a rotating Chair and since April 2009, Ministers from each of the co-sponsoring government departments have either Chaired or attended the Board. The Board's membership is varied in order to capture a wide range of expertise and comprises senior decision-makers responsible for policy and issues related to deaths in custody from a range of organisations including:

- Association of Chief Police Officers (ACPO)
- Care Quality Commission (CQC)
- Department of Health
- HM Inspectorate of Constabulary
- HM Inspectorate of Prisons
- Home Office
- Howard League for Penal Reform
- Independent Advisory Panel (IAP) on Deaths in Custody
- Independent Custody Visiting Association
- Independent Monitoring Board
- Independent Police Complaints Commission (IPCC)
- INQUEST
- Joint Committee on Human Rights
- National Offender Management Service (NOMS)
- Office of the Children's Commissioner for England and Wales
- Prison Reform Trust
- Prisons & Probation Ombudsman
- Samaritans
- The Coroners Society of England and Wales

- UK Border Agency (UKBA)
- Youth Justice Board (YJB)

The second tier of the Council is the Independent Advisory Panel (IAP) on Deaths in Custody. The IAP plays an important role in helping to shape government policy in this area through the provision of independent advice and expertise to the Ministerial Board. It also provides guidance on policy and best practice across sectors and makes recommendations to Ministers and heads of key agencies to address any gaps.

The IAP is supported by a broadly based 'virtual' Practitioner and Stakeholder Group (PSG), which forms the third tier of the Council. There are currently over 80 confirmed members of the Practitioner and Stakeholder Group representing a range of organisations including the police, prisons, Youth Justice Board, UK Border Agency, private sector custody providers, DH/NHS secure services, inspectorates, investigative bodies and non-governmental organisations (NGOs).

The Ministerial Council incorporates senior decision-makers, experts and practitioners in the field and the aim is that this extended, cross-sector approach to reducing deaths in custody will allow for better learning and sharing of lessons across the custodial sectors.

To ensure that the Ministerial Council functions effectively, a small Secretariat was established to foster good co-ordination between the Ministerial Board, the IAP and the PSG. The Secretariat acts as a central hub for sharing learning and information about the means of preventing deaths in custody. The Secretariat is also responsible for maintaining the IAP's website and issuing regular communications to provide an update on the work of the IAP, new developments and any lessons learned.

Section 2: Statistical Overview of all Deaths in State Custody

The figures available to the IAP show that between 1st January 1999 and 30th September 2010, there were 6,496 recorded deaths in state custody. This is an average of 541 deaths per year. Each one of these deaths brings with it a significant emotional impact not only upon the families and friends of the individual involved, but also upon the staff responsible for their care and welfare.

The deaths of those detained under the Mental Health Act and those in prison custody account for 92% of all deaths in state custody, accounting for 62% and 30% respectively.

Figure 1.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010 [5]
Prison[1]	149	147	142	164	182	207	175	153	185	165	168	152
Police[2]	36	30	29	32	34	39	28	26	23	18	16	3
In-Patient Mental Health Setting	449	406	346	307	331	310	339	364	325	327	290	201
Approved Premises	9	24	22	21	12	20	17	10	17	15	9	9
Secure Young People's Estate[3]	0	0	0	0	0	2	0	0	0	0	0	0
Immigration detention[4]	0	1	0	0	2	4	2	1	0	0	0	1
Total Deaths in State Custody for England and Wales	**643**	**608**	**539**	**524**	**561**	**582**	**561**	**554**	**550**	**525**	**483**	**366**

1. Includes deaths in custody or released on licence for medical reasons, and the 13 deaths of young people under 18 years of age (but excludes Secure Training Centre/Secure Children Home deaths). Excludes prison-service run IRCs, these have been included in the immigration figures.

2. Deaths in or following police custody as defined in category A of the PACE Act 1984. Figures for 1999-2004 are for financial year, and figures for 2005 onwards are by calendar year.

3. These figures include deaths which have occurred in Secure Training Centres (STCs) and Local Authority Secure Children's Homes (LASCHs), but exclude deaths which occur in Young Offender Institutes (YOI). These deaths are included in the figures for the Prison Service.

4. These figures include the three prison service run IRCs at Haslar, Dover and Lindholme.

5. Figures for 2010 include deaths which have occurred up to and including 30th September 2010, apart from the police whose figures are to the 31st March 2010.

The Secretariat is working towards developing a standardised and comprehensive statistical summary of deaths in state custody between 1st January 1999 and 31st December 2010, which for the first time will show a full demographic breakdown of all recorded deaths in state custody and allow for a more accurate comparison of mortality rates across the sectors. These statistics, based on official government figures will be broken down by ethnicity, gender, age and cause of death and will be published by the IAP in summer 2011.

Section 3: Progress Made by the IAP since April 2009 & Future Priorities for the Work of the Panel

The IAP is now over eighteen months into its initial three-year term and this section provides an overview of the progress of our six working groups and key achievements during this period.

1. Use of Physical Restraint

This working group, which is being led by Professor Richard Shepherd, is considering the issue of the use of physical restraint in state custody. In March 2010, this working group presented three recommendations to the Ministerial Board, which were endorsed by Board members. These were:

1. ***To undertake a review of the Rule 43 Reports, narrative verdicts and investigation reports relating to those deaths where the use of restraint was identified as a contributory factor, or direct cause of death***

The IAP recognised that there was a huge amount of learning, which could be extrapolated from Coroners' Rule 43 Reports and narrative verdicts, as well as investigative reports into deaths where restraint was identified as either a direct cause or contributory factor. The aim of this work is to identify any trends particularly in relation to ethnicity, learning difficulties and mental health and relevant learning for dissemination across the custodial sectors. The Secretariat has collated this information and begun work on the analysis. The Faculty of Forensic and Legal Medicine (FFLM) at the Royal College of Physicians have expressed an interest in contributing to this work. A paper summarising the emerging themes and issues will be presented to the Board in June 2011.

2. ***To hold a cross sector workshop involving the training leads on restraint from each of the custody sectors to identify common approaches to restraint and to share examples of good practice***

This workshop was held in May 2010. A report, which is available on the IAP's website,[2] includes a summary of the main discussions and issues from the day, as

[2] You can access the full report by visiting: http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/01/Report-of-the-IAPs-Cross-Sector-Restraint-Workshop.pdf

well as statistics on the number of restraint related deaths and an overview of each custodial sector's policies and guidance on the use of restraint. The report also contains a number of recommendations to address the gaps highlighted during the workshop, which were that:

- *Local police forces submit use of force and restraint statistics on an annual basis to a suitable central body for monitoring and analysis purposes.*
- *The custodial sectors develop protocols to ensure that investigations are triggered in cases where the use of restraint has resulted in the near death or serious injury of an individual.*
- *The Restraint Accreditation Board (RAB) in due course should ensure that the systems of restraint used in Local Authority Secure Children's Homes are accredited.*
- *The creation of national guidance for UK Border Agency (UKBA) detention staff on how to safely restrain children under the age of 10.*
- *Discussions are undertaken with RAB to establish the feasibility of them holding an extended meeting once a year to include representatives from all of the custodial sectors in order to share best practice and learning. If this is not feasible, consideration should be given to the creation of a new high-level restraint group with full custodial representation.*

The Chair of the IAP wrote formally to the co-sponsors of the Ministerial Council (Department of Health, Ministry of Justice and Home Office) in January 2011 to request confirmation of their position on the viability of implementing the specific recommendations that relate to their departments and where relevant provide an overview of the proposed steps and timetable for taking these forward.

3. To commission a review of the medical theories and research relating to restraint related deaths in custody

This research will focus on a number of specific medical theories connected to restraint related deaths, such as positional asphyxia and excited delirium in order to gain a greater understanding of the physiological and pathological causes of these types of deaths. The findings from this review will enable the IAP to identify whether the restraint training packages used by each of the custodial sectors adequately mitigate the medical risks related to restraint. This study commenced in early

February 2011 and a final report, summarising the key findings and recommendations will be presented to the Board in October 2011.

The aim of these three strands of work is to feed into the development of a series of common principles, which it is hoped the custodial sectors will adhere to as a minimum in order to bring about an improvement in operational practices to reduce the number of restraint related deaths in the future. These will cover factors such as the content, delivery and accreditation of training, the collection, collation and analysis of statistics on the use of restraint, the identification of vulnerable groups who may be particularly at risk including those with a medical condition, psychiatric disorder or drug/alcohol consumption and recovery procedures following the use of restraint. These principles will be presented to the Ministerial Board for endorsement in early 2012.

2. Cross Sector Learning

This working group, led by Deborah Coles, is investigating the effectiveness of existing investigation mechanisms in ensuring the timely dissemination of cross sector learning following a death in custody. In March 2010, this working group made a series of recommendations to the Board in an attempt to strengthen the procedures for sharing learning from deaths in state custody, both within individual organisations and across the custodial sectors. The recommendations, which were supported by Board members were:

1. ***To seek more qualitative evidence in relation to the current systems in place for sharing the learning and monitoring the action plans developed following a death in custody***

The IAP has undertaken a short review to identify the various investigative procedures undertaken within each of the custody sectors following a death. The initial scoping work carried out to date has shown a variety of different approaches within the individual sectors in relation to sharing learning following a death in custody. Some of which function at a national level and some more at a local level and further work is required to determine the effectiveness of these. A key concern for the IAP is the fact that the different sectors are working in silos and operating in isolation from each other.

The meetings held with stakeholders so far have highlighted that there are a number of good written policies in place within individual sectors for sharing the learning identified following a death in custody both on a local and national basis. However, the IAP is not in a position currently to assess the effectiveness of these and further qualitative work is required to determine the difference that these policies make in practice in terms of contributing to a reduction in deaths in custody. The next stage of this work is for the IAP to obtain specific examples from each of the sectors to illustrate how the learning acquired has been used to inform policy and training, fed back to operational staff and communicated to bereaved families to illustrate any gaps in processes or examples of good practice, which could be replicated across the sectors. This work has been prioritised in the IAP's work programme for 2011/12.

2. ***That a specific reference to learning from deaths in state custody is included within the remit of the new Chief Coroner and that the new Chief Coroner is invited to sit on the Ministerial Board on Deaths in Custody***

The IAP recognised that the appointment of a new Chief Coroner, a key element of the Coroners and Justice Act (CJA) 2009 would provide a mechanism to ensure that learning from deaths in state custody was given a higher priority. The IAP is disappointed by the government's recent announcement that as part of the public bodies reform, the Chief Coroner of England and Wales would be abolished both in body and function. The IAP understands that the Government is planning to bring forward some of the measures from Part 1 of the CJA in line with the original deadline of April 2012 and work is ongoing across Government to identify whether and if so, how other measures in the 2009 Act could be implemented. The IAP will continue to monitor these developments during 2011/12.

3. ***That guidance is developed specifically for Coroners to assist them with the production of Rule 43 Reports***

The IAP recognises that two key resources in terms of highlighting valuable lessons for preventing future deaths are Rule 43 Reports and narrative verdicts. The inconsistency of the format and content of Rule 43 Reports was highlighted as an issue at a meeting that the IAP held with a small group of coroners in January 2010. The consensus was that the development of a set of guidelines for coroners to assist with the production of Rule 43 Reports would be beneficial. The aim of this guidance

would be to ensure that a number of minimum requirements were met by Coroners so that these reports were as helpful as possible from a learning perspective and to standardise the composition to assist with analysis. It has been agreed with the Coroners and Burials Unit (CBU) within the MOJ that the IAP will feed into the development of this guidance to ensure the importance of learning from deaths in custody is emphasised. The CBU has held two training courses for Coroners in June and November 2010, which included modules around the composition of Rule 43 Reports, but as yet the development of formal guidance is still to be initiated. The IAP will be working with the CBU in 2011/12 to progress this piece of work.

This group has also worked with the CBU to introduce a number of changes to update IRIS, the coroner case management system. These changes will allow coroners to distinguish between deaths in prisons, police custody, immigration detention, approved premises and those who die whilst detained under the Mental Health Act (MHA), as they were previously unable to record the place of death on the IRIS system. This will allow for better analysis and comparison of death in custody statistics.

To support the work of this group, the Secretariat has also been working with this unit to collate all available Rule 43 Reports and narrative verdicts[3] relating to deaths in state custody. A key role of the IAP is to improve the systems in place to allow for better learning and sharing of lessons across the custodial sectors in order to prevent future deaths. The IAP acknowledges that further analysis of these resources is required. A tender exercise will be undertaken to commission an organisation to undertake further work to identify how the existing systems in place for sharing the learning from these both within individual custodial sectors and across them could be strengthened and any key learning points for cross sector dissemination. As part of this work, a sample of reports will be selected and the action taken by individual custodial sectors in response to the recommendations made will be identified in order to determine the impact these are having in terms of sharing learning and contributing to the prevention of future deaths. The IAP will report on the findings of this work in autumn 2011.

[5] Narrative verdicts are now quite common in inquests, as they give the jury the opportunity to explain, in their own words, their findings on hearing all of the evidence. A narrative verdict can be in the form of questions, which the jury have to answer or a more free form where the jury can put the verdict in their own words.

4. ***To issue a joint questionnaire with the Coroners Society to obtain accurate data on the number of outstanding inquests into deaths in custody and the reasons for delays to inquests***

In August 2010, the IAP and the Coroners Society of England and Wales issued a joint questionnaire to coroners in order to obtain accurate data on the number of outstanding inquests into deaths in custody and the reasons for any particular delays. To date, the IAP has received responses from 98 of the 100 coroners. Initial analysis undertaken has indicated that the main reasons for delays to inquests include:

- *The disproportionate number of custodial institutions/settings in certain Coroner's jurisdictions that give rise to Article 2 type inquests;*
- *Delays to receiving draft PPO reports as a result of delays to toxicology/histology reports and/or clinical reviews;*
- *Delays to receiving draft IPCC reports;*
- *Securing relevant witnesses and experts to provide evidence;*
- *Difficulties with securing appropriate court accommodation, especially if the court room needs to be suitable for prisoner witnesses or large enough to hold a jury and;*
- *Difficulties in synchronising counsel's diaries*

The Secretariat are in the process of completing further analysis of the returns received and the IAP look forward to continuing to work with the Corners Society in 2011/12 with a view to developing a series of recommendations to try and address these delays.

3. Deaths of Patients Detained under the Mental Health Act (MHA)

Simon Armson is leading this working group, which is examining the specific issues relating to the deaths of patients detained under the Mental Health Act (MHA). Given the considerable attention that has already been given to deaths from non-natural causes, in the first instance this working group is considering the deaths that occur as a result of natural causes, particularly those that could be considered as premature.

In June 2010, this working group held a consultation meeting with stakeholders and it was agreed that further work to review the reception and discharge processes for those detained under the Act would be undertaken to ensure that physical health issues are being sufficiently covered as part of these processes. Discussions undertaken with the Care Quality Commission (CQC) have indicated that they are supportive of this proposal and they have agreed in principle that an audit could be undertaken by the Mental Health Act Commissioners, who visit places of detention to ensure that the powers of the Act are properly used. The IAP are currently undertaking discussions with the CQC to agree an appropriate format and timescale for this work.

The IAP have been working in conjunction with the Department of Health (DH) to analyse diagnostic information held by the CQC in relation to the natural cause deaths of those detained under the Act between 2004 and 2009. This analysis will be used to strengthen the recommendations made by this working group. This group have also inputted into the revision of the CQC's death notification form, which is completed by Trusts following the death of a patient detained under the MHA. It was felt that the form should request more information about any physical health needs of the deceased in order to allow the CQC to identify those that could potentially be premature natural cause deaths and have important implications for policy/practice. The findings and recommendations from this working group will be presented to the Ministerial Board in March 2011.

4. Article 2 Compliant Investigations

This working group led by Professor Philip Leach is building upon the work undertaken by the Forum for Preventing Deaths in Custody, which examined whether the current arrangements for investigating deaths in custody complied with Article 2 of the European Convention on Human Rights (ECHR).

A series of meetings have been held with stakeholders to identify and discuss the priorities in relation to Article 2 from a mental health, prisons/policing and coronial perspective. These meetings have highlighted two specific areas that this group will be focussing upon in 2011/12. Firstly, the IAP believes that the National Patient Safety Agency (NPSA) good practice guidance on the 'Independent Investigation of Serious Patient Safety Incidents in Mental Health' would benefit from being revised in

order to strengthen its focus around Article 2 investigations[4]. The IAP is aware that the Department of Health is proposing to abolish the NPSA as a result of the arms length body review published in July 2010 and will explore the viability of this proposal with the Department.

Secondly, this working group will be undertaking further work to consider whether the quality, timescales for completion and level of independence of clinical reviews into deaths in prison custody are adequate. Clinical reviews form a key part of the investigations undertaken by the Prisons and Probation Ombudsman (PPO). The IAP recognises that further research in this area would be beneficial and is keen to undertake joint work with the PPO and Offender Health (DH) to progress this in 2011/12. The Panel acknowledges that the timing of this work is opportune given the potential implications that the NHS reforms being introduced as part of the Health and Social Care Bill 2011 could have upon the commissioning arrangements for these reviews.

The IAP is also planning to undertake further consultation with stakeholders in 2011 to determine whether the production of cross sector guidance on the principles of Article 2 compliance would be helpful. The findings and recommendations from this group will be presented to the Ministerial Board in summer 2011.

5. Information Flow through the Criminal Justice System

This working group is examining how information about an individual's health needs and their risk of suicide/self harm could be more effectively shared during their journey through the Criminal Justice System. Professor Stephen Shute is leading this work.

In April 2010, a questionnaire was issued to stakeholders to seek their views on what the key priorities for the work of this group should be. Over sixty responses were received and one of the key themes to emerge was a perceived gap in relation to the provision of comprehensive national guidance and training on the principles of information sharing. Local variations in information sharing practices and concerns

[4] When a death in state custody occurs, the subsequent investigation into that death must satisfy a number of criteria under Article 2 of the European Convention on Human Rights, which protects an individual's right to life. One of the main criteria is that the investigation must be independent of the establishment where the death occurred.

that appropriate information sharing was being hindered because of a misunderstanding of the principles of data protection were also highlighted.

These issues were explored further at a focus group meeting held in December 2010, which involved policy and training leads from across the custodial sectors. It was agreed in principle at this meeting that the development of further cross sector guidance on the type of information that can be shared and with whom, as individuals move through the criminal justice system would be beneficial in providing agencies with a clear and consistent information sharing framework. The IAP will be making a recommendation to the Board in March 2011 in relation to this.

A visit to a prison establishment in October 2010 highlighted issues around the transfer of prisoners on an open Assessment, Care in Custody and Teamwork (ACCT) document and the Person Escort Record (PER) form, which captures risk information relating to a prisoner prior to and during the escort procedure. Issues around the PER were also raised at the focus group meeting held in December in relation to the quality and consistency of the information captured on these forms. A visit to a police custody suite is planned for early 2011, as police custody is often the first point of contact individuals have with the criminal justice system. This visit will allow the IAP to observe how effective the initial mechanisms for capturing and sharing information are. A paper summarising the findings of this group and recommendations to address any gaps will be presented to the Ministerial Board in March 2011.

6. Risks Relating to the Transfer and Escorting of Detainees

This working group led by Dr Peter Dean is exploring the particular risks relating to the transfer and escorting of detainees and the training provided to escort staff. A key focus will be the revised Person Escort Record (PER) in order to learn as much as possible about the process and how any benefits from it can be maximised. This group will also be considering safety issues associated with vehicle design.

A meeting was held in July 2010 with officials from the UK Border Agency (UKBA) to discuss the specific challenges faced during the deportation process. One of the issues raised was the difficulties encountered by UKBA in acquiring risk information from some prison establishments during the handover process for time served foreign national prisoners. This information is crucial as it feeds into the

development of an individual's deportation strategy. Dr Dean also attended the focus group meeting chaired by Professor Shute in December 2010 because of the cross over between the work of these two groups. Some attendees felt that the questions relating to an individual's risk of self-harm/suicide on the PER form needed further refinement in order to capture information on those who were at a very high level of risk more effectively.

A meeting with officials from the Metropolitan Police Service (MPS) was also held in December 2010 to discuss whether the vehicles used for transportation were as safe as possible from a design perspective. Specific issues were highlighted in relation to the restrictions on movement in the back of police vans, which can potentially cause problems in road traffic accidents or when the detainee needs restraining. There was also concern raised about the lack of specific guidance on risk assessment procedures for the transfer of detainees in police response vehicles. The IAP are considering the benefits of issuing a questionnaire to individual police forces in 2011/12 to identify whether the vehicle safety issues encountered by the MPS are replicated across other forces and any further design issues for consideration. This working group will be presenting its emerging findings and recommendations to the Ministerial Board in summer 2011.

Additional Work

7. Family Listening Event

In March 2010, the IAP hosted a family listening event, which gave Panel members the opportunity to learn about the experiences faced by families affected by the death of a relative whilst detained within state custody. Sixteen family members attended the event, ten of which had been affected by a death in prison and six a death in or following police custody. The discussions were of huge benefit to Panel members. Some of the key points raised by the families on the day included:

- *The need for families to receive clear guidance on bereavement services and independent sources of advice and support.*
- *Concerns about the limited information provided to families and unrealistic assessments from investigating agencies about the timescales for the investigation.*

- *The difficulties in information being disclosed to families regarding the circumstances of the death.*
- *The strain placed on families caused by the delays in the investigation and inquest process.*
- *A lack of communication from the authorities with assurances or promises that their procedures were being looked at and where found to be at fault, changed.*
- *A need for custodial institutions to ensure that lessons were learned from deaths in custody so other families would not have to go through the same experiences.*

A report summarising the discussions and key themes from the day and the families' suggestions for change is available on the IAP's website[5]. In terms of next steps, it was agreed at the Ministerial Board meeting in June 2010 that the IAP would undertake further work with the co-sponsors of the Ministerial Council to explore whether a standardised cross sector approach could be developed for the following:

1. *The procedure for informing families about the death of a relative whilst in state custody.*
2. *The key information sources shared with families following a bereavement.*
3. *A post-inquest protocol to ensure that families are kept informed of subsequent actions and changes to policies and procedures as a result of the death, the investigation and inquest.*

In September 2010, Deborah Coles, the IAP member leading this work met with representatives from the UK Border Agency (UKBA), National Offender Management Service (NOMS), Independent Police Complaints Commission (IPCC), Prisons and Probation Ombudsman (PPO), the Care Quality Commission (CQC), the Coroners Society, INQUEST and the Department of Health to discuss taking forward the recommendations from this listening event. It was agreed at this meeting that the IAP would explore the development of a basic leaflet for bereaved families outlining the role of the different agencies involved following a death in custody and signposting them to additional sources of support and advice. It was also agreed that a set of overarching principles covering good family liaison services, which the custodial sectors could all adhere to as a minimum would be produced. The IAP has prioritised this work within its work programme for 2011/12 and hopes to progress this work over the next six months.

[5] You can view the full report by visiting: http://iapdeathsincustody.independent.gov.uk/news/iap-publishes-its-report-on-the-family-listening-day/

The IAP recognised that family members affected by the death of a relative whilst detained under the Mental Health Act were not represented at this event and are planning to hold an event, specifically for these families in spring 2011 to ensure that their experiences and views feed into the work being undertaken in this area.

8. Communicating with Stakeholders

The IAP's independent website was launched in February 2010 and is an essential tool for sharing the work of the Panel with stakeholders. The website includes details about the Panel members, minutes of IAP meetings, a 'news' section, learning identified from deaths and near deaths in custody, relevant research and good practice documents from across the custody sectors, guidance on policy and best practice produced by the IAP, consultation exercises, e-bulletins and links to relevant external websites. The site also includes copies of reports of independent investigations into deaths and near deaths in state custody. Regular E-bulletins also provide stakeholders with an update on the key pieces of work being taken forward by the IAP.

The IAP will be holding its first national stakeholder consultation workshop on 1st March 2011. This event will be the first time that the IAP has brought all members of its 'virtual' Practitioner and Stakeholder Group together. Through plenary and workshop sessions, the event will present stakeholders with an opportunity to influence the direction of the Panel's six working groups and provide the IAP with an opportunity to discuss and explore potential recommendations with stakeholders to ensure they are grounded in operational reality. It will also offer an opportunity to share best practice and any lessons which may have cross sector applicability, as well as provide a networking opportunity for attendees.