Independent Advisory Panel on
DEATHS IN CUSTODY
IAP E-Bulletin · Jul 2011 · Issue 5

Message from the Chair of the IAP

Welcome to the fifth E-bulletin from the Independent Advisory Panel (IAP) on Deaths in Custody. This E-bulletin provides an update on the work that has been taken forward by the Panel since March 2011.

In February 2011, we published our mid-term report, which reflected on the achievements of the Panel over the last eighteen months, as well as committing to work that will be taken forward in the remainder of its term. One of our commitments was to publish a comprehensive statistical breakdown of all recorded deaths in state custody between 1 January 1999 and 31 December 2010. This represents an important piece of work for the Panel as this is the first time that all recorded deaths in state custody will be broken down by ethnicity, gender, age and cause of death, have been presented together in a single format. The IAP is now in receipt of all the data, and will be publishing this report in September 2011.

In June 2011, I attended the IAP's expert medical seminar on the theories behind restraint deaths. Both Professor Richard Shepherd and I thought it was a very productive day and the discussions from the seminar will be fed in to the review of the medical theories behind restraint related deaths, which is due for completion later this year. These discussions will help ensure that the review is comprehensive enough to enable a greater understanding on why people die following restraint.

Also in June, the Ministerial Board on Deaths in Custody met for the seventh time. Paul Burstow MP, Minister of State for Care Services at the Department of Health chaired the meeting. The Panel presented a series of papers to the Board, which were well received.

More generally, this E-bulletin provides an update on the progress of the six IAP workstreams, details of the IAP's Learning Library, information on the forthcoming family listening day for bereaved families affected by the death of a relative detained under the Mental Health Act (MHA), the evaluation of the Ministerial Council on Deaths in Custody and an invitation to join our Practitioner and Stakeholder Group.

I hope that you find the issues covered in this E-bulletin interesting. As always, should you wish to comment on any of the issues raised or have any questions, please feel free to contact the Secretariat who will ensure that any comments are passed onto me and the other members of the Panel.

Thank you,

Toby Harris

Contents

IAP Publish Statistical Summary of all Recorded Deaths in State Custody

In June 2011, the Panel wrote to the individual custody sectors to acquire data on the number of recorded deaths within their sectors between 1 January 1999 and 31 December 2010. The Panel are now in receipt of this data and have begun work on analysing the figures. The full report will be available to download from the IAP's website in September 2011. The Secretariat will also be circulating a copy of this report electronically. If you have any comments about this work, please contact the Secretariat by emailing iapdeathsincustody@noms.gsi.gov.uk

Update on the Review of the Medical Theories and Research on Restraint Related Deaths

As reported in the April edition of the E-bulletin, Caring Solutions (UK) Ltd, in conjunction with the University of Central Lancashire, are conducting a review of the medical theories and research relating to restraint related deaths. On 1 June 2011, an interim report containing the initial findings was submitted to the Secretariat. The report seeks to clarify research from national and international literature to ascertain any common findings in order to provide guidance for staff on safe and effective restraint techniques where there is no other resort in the prevention and management of violent and aggression. The interim report has highlighted the following groups who may be vulnerable to the use of restraint:

- Individuals with serious mental illness.
- Individuals with learning disabilities.
- Black and Minority Ethnic (BME) groups.
- Individuals with high Body Mass Index (BMI).
- Men aged between 30-40 years.
- Children and young people.

The report has also identified the following medical theories on why people die after being restrained:

- Pre-existing conditions i.e. Chronic Obstructive Pulmonary Disease.
- Stress related cardiomyopathy.
- Positional asphyxia (in prone, supine or basket hold restraint).
- Catecholamine hyperstimulation as a result of stress.
- Alcohol / drug intoxication.
- Excited delirium / acute behavourial disturbance.
- Exertion leading to acidosis.
- Thromoembolic disease.

As part of this review, the Panel believed it was important to canvass expert views to further inform this work. On 10 June 2011, an expert seminar was held with the aim of testing out the emerging medical theories and to gain insights on whether there were any further theories which had not already been identified. The seminar was well attended, with representatives from a range of educational, research and medical establishments including: INQUEST, Restraint Accreditation Board (RAB), Royal Brompton Hospital, Metropolitan Police, HM Coroner for Essex, University of Liverpool, Coventry University, University of Glamorgan, Kings College London, Caring Solutions, University of Central Lancashire and InfoTech UK.

A strong emerging issue from the day was that there have been more restraint related deaths than those included in both this review and the IAP's cross sector restraint report. Attendees believed there would be value in strengthening mechanisms to capture information on these deaths, which the Panel will explore as part of its longer term work plan. There was also a consensus amongst attendees that environmental and interpersonal factors needed to be referenced in the review. For example, how certain occupational groups behave and how attitudes / behaviours that lead to the use of restraint could be altered. These discussions will be fed into the final report, which is due to be submitted to the IAP in September 2011. It is hoped that 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. The report will be presented to the Ministerial Board in October 2011 and an update on this will be provided in the November E-bulletin.

Ministerial Board on Deaths in Custody

The seventh meeting of Ministerial Board on Deaths in Custody was held on Tuesday 21 June 2011 and was chaired by the Minister of State for Care Services at the Department of Health, Paul Burstow MP. Professor Philip Leach, Dr Peter Dean and Professor Richard Shepherd presented reports and recommendations on each of their workstreams. Further details on their recommendations can be found in the Update on the IAP Working Group section.

The Youth Justice Board (YJB) also presented a paper on deaths of young people, including a small number who had recently left custody; the Prisons and Probation Ombudsman (PPO) provided an update on its performance and plans for research and the Howard League for Penal Reform presented a paper on unclassified deaths in prisons.

Update on the IAP Working Groups

Below is a summary of the progress made by each of the IAP's six workstreams since the last E-bulletin:

Cross Sector Learning

Data from coroners about the number of death in custody cases and reasons for any delays to inquests has been analysed. The Panel is in discussion with including the Coroners' Society, about how to present the information and make recommendations to address the reasons for delay. This will be incorporated into an update to the Ministerial Board in October 2011.

The procurement exercise to commission an analysis of Rule 43 Reports and narrative verdicts on deaths in custody, to identify how systems in place for sharing learning should be strengthened, has been delayed because no suitable provider could be secured to undertake the research. The IAP will be re-issuing the amended specification shortly in order to take this work forward in the Autumn.

Plans are underway for a further family listening day on 22 September, to hear from bereaved families, whose family members died when detained under the Mental Health Act (MHA). Feedback from the day will inform the Panel about how to take forward their work on family liaison. Further details on this are included later in the E-bulletin.

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

Following its paper to the Ministerial Board in March 2011, the Panel has made progress in taking forward recommendations made to the Department of Health (DH) and Care Quality Commission (CQC) about natural cause deaths of detained patients.

Action is being taken by DH and CQC to analyse existing data and to collect relevant future data to examine reasons for the high numbers of deaths from myocardial infarction (MI) and pulmonary embolism (PE). CQC has also incorporated feedback from the Panel on its Death Notification form, in order to collect data on physical health diagnosis and treatments for all patients who die whilst detained. DH is working with the NHS Information Centre (IC) to undertake further scoping to identify data on detained patients. From 2011/12, the Mental Health Minimum Data Set (MHMDS) will provide a richer source of data on natural cause deaths.

Simon recommended that inpatient mental health providers should have up to date protocols for responding to medical and surgical emergencies. CQC compliance guidance specifically mentions the need for staff to recognise quickly when a patients becomes seriously ill, and to respond immediately to their needs.

The Panel has discussed with DH how they can ensure a focus on improving the physical health of detained patients. The National Clinical Director for Health & Criminal Justice and National Clinical Director for Mental Health have agreed to raise the profile of premature deaths of detained patients with the professional bodies via the Interprofessional Collaborative at their meeting in September.

Article 2 Compliant Investigations

Professor Philip Leach presented the IAP findings and recommendations on Article 2-compliant investigations of deaths in custody to the Ministerial Board in June 2011. Most recommendations were accepted in principle, although there is work to do with custody sectors to enable their implementation. The recommendations addressed four main areas: (i) deaths of those detained under the Mental Health Act (MHA); (ii) deaths in prisons; (iii) deaths of children who die in secure children's homes (SCHs) and; (iv) inquests.

Recommendations in relation to deaths of detained patients addressed the need for a review of the quality of independent investigations carried out by Strategic Health Authorities; revision of the NPSA guidance on Independent Investigation of Serious Patient Safety Incidents in Mental Health and that the NHS Commissioning Board (NHS CB) should produce guidance to clarify when independent investigations should be commissioned. The recommendations were accepted in principle, pending further discussion with Department of Health as the design of the NHS CB emerges.

Professor Leach recommended that the Care Quality Commission (CQC) should take on a specific role in conducting or commissioning independent investigations. CQC agreed that this was relevant to their lead role in reviewing deaths of detained patients but that implementation should wait until final decisions had been made on the function of the NHS CB.

The Prisons and Probation Ombudsman (PPO) agreed to work with the IAP to monitor the impact of action planned to reduce the length of delays to clinical reviews of deaths in custody.

A meeting is planned between the Panel, Department for Education, Ofsted and Ministry of Justice, to discuss how to take forward the recommendation that the PPO should investigate deaths of children in secure children's homes (SCHs).

A recommendation that the future model for standard-setting and oversight of coroners should focus on deaths in custody will be discussed at the next Ministerial Board, which is due to be attended by Coroners and Burials Unit.

Use of Physical Restraint

In June 2011, Professor Richard Shepherd presented two papers to the Ministerial Board. The first paper summarised the responses received from the Co-sponsors of the Ministerial Council, the Youth Justice Board (YJB) and the Restraint Accreditation Board (RAB) confirming their official position on the viability of implementing the specific recommendations contained in the IAP's cross sector restraint report. Of the five recommendations, two were not accepted. The responses to the first, which was for custodial sectors to develop protocols to ensure investigations are triggered in cases of near death following restraint, indicated that these mechanisms were either already in place, or have been developed since the report was presented to the Board in October 2010. The second, which called for local police forces to submit use of force and restraint statistics on an annual basis for monitoring and analysis purposes, was rejected by the Home Office. It was argued that whilst there was nothing to prevent individual forces from collating this data locally, at the Police Federation Conference on 18 May 2011, the Home Secretary had re-stated her commitment to driving down bureaucracy in the police. The Home Office position is that the recommendation was counter to that drive.

The second paper contained an analysis of Rule 43 reports, narrative verdicts and investigative reports where restraint was identified as either a contributory factor, or direct cause of death. The analysis was based on an examination of 29 individual deaths in custody. The key themes to emerge from this work include:

- There were 28 male deaths and one female death.
- In six of the cases, positional asphyxia was listed as either a primary or secondary cause of death. Acute behavioural disorder (also known as excited delirium) was listed in six of the cases.
- Nine individuals were from Black and Minority Ethnic (BME) groups and 17 were classified as white.
- 12 individuals had mental health problems at the time of their death. Five individuals had been diagnosed as suffering from schizophrenia and two individuals were diagnosed with paranoid schizophrenia.

- In seven of the cases, the reports contained concerns around the lack of staff awareness concerning the dangers associated with positional asphyxia, and to a lesser extent, acute behavioural disorder, during the restraint incident.
- In three of the cases, serious concerns were raised about the use of prone restraint as a technique and the prolonged period of time this was used.

Professor Shepherd will use the themes identified during this analysis, and, combined with the review of the medical theories as discussed earlier in the E-bulletin, will help to inform the development of common principles, which it is hoped custodial sectors will adhere to as a minimum. The aim of these will be to bring about an improvement in operational practices across the custodial sectors in order to reduce the number of restraint related deaths in the future. These principles are due to be presented to the Ministerial Board early in 2012.

The Risks Relating to the Transfer and Escorting of Detainees

In June 2011, a paper on the risks relating to the transfer and escort of detainees was presented to the Ministerial Board. One of the main concerns highlighted in the paper was the difficulty of transferring detainees subject to Section 136 of the Mental Health Act (which states that the police can remove from a public place to a place of safety a person who appears to have a mental disorder and who needs immediate help). Previous research conducted by the Independent Police Complaints Commission (IPCC) highlighted that police officers are often unable to take Section 136 detainees to a place of safety other than a police station, either because it simply does not exist or because hospital staff refuse to accept detainees who are intoxicated or violent. The IAP believe that police custody is not the best place for Section 136 detainees given the vulnerabilities of the detainee, and the lack access to mental health professionals and a recommendation was made in order to address these concerns.

Other issues highlighted include problems with restraining young people who are transferred in cars from court to secure children's homes; transferring individuals suffering from the effects of drug & alcohol consumption; prioritising appearances at court for young people and other vulnerable groups; and concerns over UKBA deportation flights. Dr Dean also contributed to the Association of Chief Police Officer's (ACPO) national specification for police vans. The Panel recommended two changes: (i) there should be clear signage in the back of the vans to remind officers of the dangers of positional asphyxia, acute behavioral disorder and head injuries. (ii) the specification should take account of the needs of rural police forces, as well as urban forces, given the different challenges for transferring detainees in such environments. The aim of the specification is to create a consistent design for police vans and ensure they meet minimum safety standards.

Dr Dean will be meeting with officials from NOMS over the summer to identify whether there can be improvement to the courts listing process to prioritise young and vulnerable people at court.

Information Flow through the Criminal Justice System (CJS)

In March 2011, Professor Stephen Shute's workstream presented a paper to the Ministerial Board. The paper, which contained three recommendations, provided a summary of the main mechanisms for collecting and sharing information about an individual's health needs and risk of suicide/self harm and an assessment of the effectiveness of these mechanisms. These were accepted in principle, pending further meetings with the custody sectors to refine and develop them. In May 2011, the IAP met with officials from NOMS, ACPO, YJB, UK Border Agency and Department of Health and it was agreed that the IAP would formulate a simple statement for practitioners, reminding all criminal justice agencies of the need to share information to provide a continuity of care for a detained individual. The IAP will be meeting with the custodial sectors throughout the summer to identify ways of disseminating this message in order to change behaviour of practitioners who deal directly with detainees. This will then be presented to the Ministerial Board in October 2011.

Further meetings were also held with NOMS and ACPO to discuss whether the Person Escort Record (PER) form, which is used to convey information relating to an individual as they are transferred through the criminal justice system, would benefit

from a formal analysis of its effectiveness. Whilst the IAP acknowledge that the current incarnation of the PER is a significant improvement on previous versions, there was agreement that a more substantial evidence base was needed to identify whether the PER was being used to its potential. The IAP has been working with the Independent Monitoring Board (IMB – who carry out visits in prison custody to monitor the wellbeing of prisoners) and the Independent Custody Visiting Associations (ICVA – who perform a similar role for police custody suites) to incorporate an analysis of PER forms during their visits. The Panel are also due to meet with Her Majesty's Inspectorate of Prisons and Her Majesty's Inspectorate of Constabulary August 2011 who have agreed in principle to undertake a review of PER forms to identify whether they were being correctly filled in.

An update on these strands of work will be included in the next E-bulletin in November 2011.

IAP Launch Learning Library

The Secretariat acts as a central hub for the sharing of learning and information about the means of preventing deaths in custody. In June 2011, the Secretariat launched the **IAP's Learning Library** which contains learning documents from the criminal justice agencies and academic establishments, which may have cross sector applicability. We are committed to developing this tool. If you think there are documents that should be included in the library, please contact the Secretariat via iapdeathsincustody@noms.gsi.gov.uk.

Family Listening Event – September 2011

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 in 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 contact. The discussions were of significant benefit to the Panel, who in conjunction with INQUEST, produced a report of the day (which is accessible through the IAP's website). However, there was recognition that family members affected by the death of a relative whilst detained under the Mental Health Act (MHA) were not represented at the event.

In February 2011, the IAP invited tenders in an open procurement exercise and undertook independent evaluation of bids from a range organisations. INQUEST has been awarded the contract for this work. The event will take place in September 2011, and the discussions will be used to inform the wider work being undertaken by the IAP on family liaison. An update on the event will be contained in the November edition of the IAP E-bulletin.

Evaluation of the Ministerial Council on Deaths in Custody

The IAP forms one tier of the three tier Ministerial Council on Deaths in Custody. The Council was established in 2009 for an initial term of three years until March 2012 and its effectiveness is currently being evaluated to inform advice to Ministers about continuation of the arrangements beyond April 2012. The purpose of the Council has been to ensure a more coherent approach to deaths in all custody sectors; including a mechanism for sharing and embedding learning to bring about a reduction in the number of deaths in custody.

The aim of the evaluation will be to seek feedback from stakeholders on the Council's effectiveness. The evidence generated from the evaluation will be used to inform a submission to Ministers, who will make a decision on the future of the Council in December 2011.

Joining the Practitioner and Stakeholder Group

There are now over 100 members of the Practitioner and Stakeholder Group, drawn from inspectorate and investigative bodies, charity and voluntary organisations, legal firms, academic institutions as well as the custodial sectors. The Panel would like to encourage families to join the group in order to hear their views on whether the focus of our work is effective in meeting families' needs. Members of the group receive regular email updates on the work of the Panel and are invited to comment on the development of its workstreams. If you would like to become a member of this group, please email Alice at alicia.balaquidan@noms.gsi.gov.uk and an invite letter will be sent to you.

Contributing to the IAP's Website

The IAP's intention is that everyone with an interest in preventing deaths in custody should have the opportunity to contribute to the IAP's work. If you have a relevant news story or research article that you feel may be of particular interest to stakeholders, please feel free to contact the Secretariat at: iapdeathsincustody@noms.gsi.gov.uk.

News

IPCC Publish Death in Custody Statistics for 2010/11
The Independent Police Complaints Commission (IPCC) published their annual death in custody statistics for 2010/11. The report reveals that there were 21 deaths in or following police contact between the 1 April 2010 and 31 March 2011: http://www.ipcc.gov.uk/en/Pages/reports_polcustody.aspx

PPO Launch their Annual Report for 2010/11
The Prisons and Probation Ombudsman (PPO) published their annual report for 2010/11. During this time period, the PPO received 4,641 complaints and opened 200 investigations into deaths, seven more than in 2009-10: http://www.ppo.gov.uk/docs/ppo-annual-report-press-notice1.pdf

MoJ Launch a Public Consultation on Public Bodies Bill
The Ministry of Justice launched a public consultation seeking views on proposals for reforms of its public bodies and statutory offices (including the Office of the Chief Coroner) to be made through the Public Bodies Bill: http://www.justice.gov.uk/consultations/reform-public-bodies.htm and will run for 12 weeks until 11 October.

PPO Report on Learning from Self Inflicted Deaths 2007-2009
In June, the Prisons and Probation Ombudsman (PPO) published a new report entitled 'Learning from PPO Investigations: Self-Inflicted Deaths in Prison Custody 2007-2009. The report provides an overview of self-inflicted deaths and draws upon information contained in over 200 investigative reports:
http://www.ppo.gov.uk/docs/self-inflicted-deaths-in-prison.pdf

Update on UKBA Review of Restraint
In June, UKBA provided the IAP with an update on their review of restraint which is looking at policies and procedures used by officers, escalation and de-escalation techniques as well as the restraint holds used in vehicles and on aircraft: http://iapdeathsincustody.independent.gov.uk/news/ukba-respond-to-iap-request-for-information-about-restraint-review/

Draft Charter for Coroner Service Published
In May, the Ministry of Justice published the draft charter for the current coroner service for public consultation. Responses are due by 5 September 2011. We are inviting all Ministerial Council stakeholders and users of our website to comment on the draft: http://www.justice.gov.uk/consultations/cp52011.htm

IAP Meeting on 17 May 2011
In May, the tenth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place. The IAP discussed how the custodial sectors were implementing the Corporate Manslaughter Act, the IAP's work plan for 2011/12 and revised communications strategy, and the IAP papers on Article 2 compliant investigations and the risks relating to the transfer of detainees. The Panel also heard from Richard Bradshaw, the Director of Offender Health, who updated the Panel on relevant areas of work of interest to the IAP.

IAP Concerns over the Proposed Abolition of the Chief Coroner
Lord Toby Harris wrote to the Coroners and Burial Unit in the Ministry of Justice to voice the Panel's concern over the proposed abolition of the Chief Coroner under the Public Bodies Bill: http://iapdeathsincustody.independent.gov.uk/news/iap-concerns-over-the-proposed-abolition-of-the-chief-coroner/

INQUEST Produce Briefing on the Death of Mr Jimmy Mubenga
In May, INQUEST published a briefing on the death of Jimmy Mubenga, who died whilst being restrained by three G4S staff during a deportation flight to Angola on 12 October 2010: http://www.inquest.org.uk/

Howard League for Penal Reform publish report on use of force
In April, Howard League for Penal Reform published a report into the use of force on young offenders in Secure Training Centres (STCs). The report reveals that there were 142 injuries on children recorded as a result of restraint on boys in prisons between April 2008 and March 2009.
To read the report, please visit the Howard League's website by clicking: http://www.howardleague.org/restraint/

UKBA respond to IAP Request for Information about Restraint Review
In March, Lord Harris wrote to UKBA to request further information on the scope of the restraint review currently being undertaken by UKBA: http://iapdeathsincustody.independent.gov.uk/news/ukba-respond-to-iap-request-for-information-about-restraint-review/

NCI Publish Study into Self Inflicted Deaths in Prison
The National Confidential Inquiry into Suicide and Homicide published a national study of self-inflicted deaths in prisons between 1997 and 2007: http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/offenders/reports/

Centre for Suicide Research Publish Near Lethal Suicide Study
The Centre for Suicide Research published two papers on psychiatric disorders in male and female prisons who made near-lethal suicide attempts: http://iapdeathsincustody.independent.gov.uk/news/centre-for-suicide-research-publish-near-lethal-suicide-study/

Prisons and Probation Ombudsman Named
In April, Nigel Newcomen CBE has been named as preferred candidate to be the next Prisons and Probation Ombudsman for England and Wales: http://www.justice.gov.uk/news/press-releases/moj/newsrelease070411a.htm

YJB Publish Study into Behaviour Management in the Secure Estate
In April, the Youth Justice Board (YJB) published a study which explores aspects of the use of restraint across the secure estate for children and young people, in conjunction with behaviour management approaches such as separation and adjudications: http://www.yjb.gov.uk/publications/Scripts/prodView.asp?idproduct=496&eP

MoJ Publish Reports made under Rule 43 of the Coroners Rules
In March, the Ministry of Justice (MoJ) published their fourth summary of recommendations made by coroners between 1st April and 30th September 2010: http://www.justice.gov.uk/news/features/features-140211a.htm

Next Issue

The next issue of the E-bulletin will be published in November 2011.