Message from the Chair of the IAP

Welcome to the sixth e-bulletin from the Independent Advisory Panel (IAP) on Deaths in Custody, which provides an update on the work that has been taken forward by the Panel since July 2011.

In October 2011, the IAP published its first statistical analysis of all recorded deaths in state custody between 1 January 2000 and 31 December 2010. The report collates comprehensive data on deaths in state custody for the first time and the Panel intend to make this an annual publication. The IAP will seek to develop the report in future years to provide a more in-depth analysis.

This e-bulletin also provides an update on the eighth Ministerial Board on Deaths in Custody; progress of the six IAP workstreams; details on the evaluation of the Ministerial Council on Deaths in Custody; the IAP’s second stakeholder consultation event planned for 2 March 2012, and invitation to join our Practitioner and Stakeholder Group and information about the IAP’s Learning Library.

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 pass them on to me and the other members of the Panel.

Thank you,

Message from the Chair of the IAP

In September 2011, the IAP held its second family listening day, which focussed on families affected by the death of a relative whilst detained under the Mental Health Act (MHA). This event was organised to feed into the wider work being undertaken by the Panel, particularly on family liaison. The discussions from this day were of significant benefit to the Panel. On behalf of the IAP, I would like to thank those families who shared their experiences with us.

Also in September, I was pleased to have the opportunity to write the foreword to the latest issue of ‘The Solution’, the monthly newsletter of Black Mental Health UK. Their work is of huge importance in ensuring that mental health issues amongst those from Black and Minority Ethnic communities (BME) remain high up on the Government’s agenda. Many of the issues Black Mental Health UK is campaigning for resonate with the Panel’s work on the deaths of patients detained under the MHA.

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The IAP’s Second Family Listening Event 2011

Family liaison is a key strand of the IAP’s work plan, looking at improving practice in the provision of sensitive and timely family liaison services following a death in custody. In March 2010, the IAP held its inaugural family listening day for families affected by a death of a relative whilst in prison custody and in or following police contact. The report was published in September 2010, which contained a series of recommendations to improve family liaison services in the custodial sectors. To build on this work, the IAP held its second family listening day on 22 September 2011. It was organised and facilitated by INQUEST who was the successful bidder in an open competition and focussed on families affected by the death of a relative whilst detained under the Mental Health Act (MHA).

The aim of the day was for the IAP to hear families’ experiences of the inquest system, investigation process and the way in which organisations had informed them of the death of their relative and managed their relatives’ cases. Facilitated small group discussions helped elicit these experiences, showing that the processes for investigating deaths in a secure mental health setting were less clearly defined than other custodial settings and that there were issues around poor communications and quality of family liaison during the investigation. Of particular concern were the lack of defined threshold for when an independent investigation should be commissioned following a self-inflicted or natural cause death, and no guidance on how to share learning between mental health trusts. A report summarising the discussions will be produced by INQUEST and will be available on the IAP’s website in due course.

The Panel will use these discussions to feed into the wider work being undertaken by the IAP on family liaison and Article 2-compliant investigations and will present the findings to the Ministerial Board in February 2012.
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IAP Publish Statistical Summary of all Recorded Deaths in State Custody

On 7 October 2011, the IAP published its first statistical summary of all recorded deaths in state custody between 1 January 2000 and 31 December 2010. This is the first time that all reported deaths had been presented together in a single format, some of which were broken down by ethnicity, gender, age and cause of death.

Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
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<th>2006</th>
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<th>2008</th>
<th>2009</th>
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<td>Prison</td>
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<td>196</td>
<td>1883</td>
</tr>
<tr>
<td>Police</td>
<td>50</td>
<td>29</td>
<td>32</td>
<td>34</td>
<td>39</td>
<td>28</td>
<td>26</td>
<td>23</td>
<td>18</td>
<td>19</td>
<td>294</td>
<td></td>
</tr>
<tr>
<td>In-Patient Mental Health Setting (detained patients)</td>
<td>406</td>
<td>346</td>
<td>307</td>
<td>331</td>
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<td>337</td>
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</tr>
<tr>
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<td>22</td>
<td>21</td>
<td>12</td>
<td>20</td>
<td>17</td>
<td>10</td>
<td>17</td>
<td>15</td>
<td>9</td>
<td>12</td>
<td>179</td>
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<tr>
<td>STCs / SCs</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>2</td>
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<td>Immigration detention</td>
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<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Total Deaths in State Custody for England and Wales</td>
<td>607</td>
<td>539</td>
<td>524</td>
<td>561</td>
<td>582</td>
<td>559</td>
<td>553</td>
<td>550</td>
<td>524</td>
<td>488</td>
<td>512</td>
<td>5998</td>
</tr>
</tbody>
</table>

1. Includes deaths of individuals 18 and over in custody or released on licence for medical reasons. These also include deaths of 15-17 year olds held in YOIs. These figures exclude two deaths that occurred in Hazelar Immigration Removal Centre, which is run by HM Prison Service in 2003 and 2004. These are included in the immigration detention figures.
2. Deaths in or following police custody as defined in category A of the PACE Act 1984.
3. These figures include deaths of young people in Secure Training Centres (STCs) and Secure Children’s Homes (SCs).
4. These figures include the three prison service run IRCs at Hazlar, Dover and Lindholme.

- Table 1 shows that in total, there were 5,998 deaths recorded for the 11 years between 2000 and 2010. This is an average of 545 deaths per year.
- A total of 607 deaths were reported in 2000 compared to 512 in 2010 (this represents a 16% reduction between the beginning and end of the reporting period).
- Deaths of those patients detained under the Mental Health Act and those in prison custody account for 5,511 of all deaths in state custody.

To read the report in full, please visit the IAP’s website by clicking here. If you have any comments about this work, please contact the Secretariat by emailing iapdeathsincustody@noms.gsi.gov.uk

IAP Stakeholder Consultation Event 2012

The IAP plan to hold a second consultation event with members of the practitioner and stakeholder group on Friday 2 March 2012. The event will mark the end of the IAP’s first term. If Ministers agree that the Ministerial Council should continue for a further term, the Panel will use discussions from the day to inform the future work plan and ensure that the priority areas contribute meaningfully to changes in operational practices and procedures to reduce deaths in custody. It will also be an ideal forum for the Panel to engage with its third sector stakeholders who have an important role to play in scrutiny of safe custody across all sectors and to evaluate the Panel’s effectiveness to identify any lessons which could help inform its second term.

The IAP received very positive feedback from attendees who attended the first event in March 2011. They welcomed the opportunity to meet others in the practitioner and stakeholder group to share best practice with other custodial sectors. The event will continue to provide stakeholders with an excellent opportunity to influence the direction of the IAP’s six work streams. The Secretariat is currently developing an agenda for the day and invitations will be issued shortly.
Deaths of Patients Detained under the Mental Health Act (MHA)

Since the last Ministerial Board in June 2011 the Department of Health (DH) has taken forward some of the recommendations Simon Armson made at the Board in March 2011 in relation to improving physical healthcare of detained patients. The issue has been raised at the inter-professional collaborative in September 2011 by Hugh Griffiths, the National Clinical Director of Mental Health at DH (this is a collaborative made up of the Royal College of Psychiatrists, the Royal College of Nursing, the British Psychological Society, the British Association of Social Workers and Allied Health Professionals). The professions were keen to raise the profile of this issue and a further meeting is being planned to devise a specific programme of work.

Cross Sector Learning

Deborah Coles presented a study to the Ministerial Board in October 2011 on delays to death in custody inquests. Deborah’s paper presented data collected from questionnaires issued to coroners in August 2010. She highlighted that, in order to satisfy the requirements of Article 2 of the European Convention on Human Rights, inquests should be held in a timely fashion to ensure there is a prompt investigation and the relevance of any learning. Delays also have a significant emotional impact on staff and families. This is the first time data on delays had been collated and the Panel are grateful to the Coroners Society of England and Wales for their assistance with issuing the questionnaire to Coroners to gather the data. Analysis of the returns from coroners about a snapshot of their caseload showed that: 49% of inquests were completed in less than 12 months; with 27% taking between one and two years; 12% between two and three years; 6% between three and four years and remaining 6% of inquests were over four years old.

Coroners had reported a number of reasons for delays, which included the disproportionate number of custodial settings in some coroner districts; waiting for investigations undertaken by other bodies; difficulties with securing dates for witnesses to attend and finding appropriate accommodation in which to hear the inquest, including accommodation for a jury. The paper highlighted that a substantial proportion – approximately 25% – of death in custody inquests were taking more than two years to complete. Whilst the IAP acknowledges that delays are sometimes unavoidable, the Panel does not believe that delays over 18 months were reasonable. A number of recommendations were made to address the delays, which the Panel will take forward in the remainder of the year.

Article 2 Compliant Investigations

On 27 September 2011, Professor Philip Leach and the Panel met with Professor Louis Appleby, the National Clinical Director for Health and Criminal Justice at DH, to discuss research on the quality of independent investigations of deaths – mainly homicides committed by mental health service users. The meeting confirmed that there appears to be very few Strategic Health Authority (SHA) commissioned independent investigations of self-inflicted deaths of detained patients. The
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Panel will consider whether to obtain information from SHAs about whether such investigations are undertaken and will consider whether research should be commissioned in this area. The Panel remains concerned that more needs to be done to ensure a system of independent investigations of deaths of detained patients.

The Chair of the IAP also raised this issue with Dame Jo Williams, Chair of the Care Quality Commission, at their meeting in September. CQC is currently reviewing its role in relation to deaths of detained patients and they are considering a threshold after which a regulatory response would be prompted. The Panel remains in dialogue with CQC on this issue.

The PPO sent feedback on the timeliness of clinical reviews they were due to receive in the previous quarter, which showed greater delays. Offender Health and the PPO are working with clinical governance colleagues in the North West SHA on a pilot project to identify solutions to improve timeliness. It is hoped that learning from this pilot will have an impact on reducing delays and improving quality.

The IAP held a meeting with the PPO, MoJ, YJB and Ofsted to discuss proposals that the PPO should extend its remit to investigate deaths in Secure Children’s Homes (SCHs). The Department for Education were unable to attend the meeting, and although they had responded positively in principle, they are now seeking legal advice before agreeing a way forward.

**Use of Physical Restraint**

At the Ministerial Board on 18 October 2011, Professor Richard Shepherd presented the review of the medical theories on restraint deaths. This review was undertaken by Caring Solutions (UK) Ltd in partnership with the University of Central Lancashire following an open procurement exercise. The report highlights that certain groups are more vulnerable to risks associated with restraint – both intrinsically, and because they are more likely to be restrained. These groups are those with serious mental illness or learning disabilities; those from BME communities; those with a high body mass index; men age 30-40 years and young people (under the age of 20).

The report is the first body of knowledge on the medical dangers of using restraint. In the first instance, the Panel is particularly interested in focusing on three issues highlighted in the report: mental health awareness; reporting mechanisms for restraint deaths and restraint reduction programs. The Panel will be working with the custodial sectors to take this work forward throughout 2011/12.

The report will also help the Panel identify a series of common principles for the safe use of restraint in order to reduce the number of restraint related deaths. The IAP is currently in discussions with the Restraint Advisory Board (RAB) about the potential for the joint development of these principles. An update on this work will be presented to the Ministerial Board in February 2012.

**The Risks Relating to the Transfer and Escorting of Detainees**

In November 2011, Dr Peter Dean will be facilitating a meeting to discuss the detention of individuals subject to Section 136 of the MHA, which follows a great deal of activity to understand the problems with provision of places of safety in health settings. Section 136 gives the police authority to remove from a public place to a place of safety a person who appears to have a mental disorder and is in need of immediate help. Dr Dean previously produced a paper for the Ministerial Board highlighting that police officers are often unable to take Section 136 detainees to a place of safety other than a police station, either because it does not exist or because hospital staff refuse to accept detainees who are intoxicated or violent. The IAP believes that police custody is not the best place for Section 136 detainees given the vulnerabilities of the detainee and the lack of ready access to mental health professionals.

The meeting will aim to identify what the current requirements for detaining people under Section 136 are, identify the current concerns around this kind of detention and seek to formulate potential steps to addressing these concerns. Representatives from the following agencies and departments have been invited: the Independent Police Complaints Commission (IPCC), Association of Chief Police Officers (ACPO), CQC, Home Office, Department of Health, Metropolitan Police, Royal College of Psychiatrists, Her Majesty’s Inspectorate of
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Joining the Practitioner and Stakeholder Group

There are now over 100 members of the Practitioner and Stakeholder Group, drawn from inspectorate and investigative bodies, lawyers, Third Sector organisations, academics and practitioners from the custodial sectors. If you would like to join this group, please contact Alice Balaquidan on the email address below. 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.

Information Flow through the Criminal Justice System (CJS)

In July 2011, the information sharing statement reminding custodial staff of the need to share information on a detainee’s risk of self-harm / suicide was developed by the IAP. A meeting was held between Professor Shute and Lord Harris with Christopher Graham, the Information Commissioner, to discuss the statement who believed it would go some way to ensuring that the Data Protection Act was not seen as a barrier to sharing information. The Panel will now consult with the custodial sectors to ensure it is readily understood and will change behaviour on information sharing.

In August 2011, Professor Shute met with officials from HMIC and Her Majesty’s Inspectorate of Prisons (HMIP), where they agreed to identify a sample of between 20-50 cases during two inspections where a Person Escort Record (PER) form had been completed by the police force being inspected and where the detainee subsequently moved to prison. The aim is to review what information relating to suicide / self-harm from the police completed PER appears on P-Nomis to check for accuracy and consistency of information. A report, summarising the findings from the inspections, will be presented to the Ministerial Board in February 2012.

In parallel to this inspection, the Panel contacted the Independent Custody Visitors Association (ICVA – responsible for visiting police custody suites) who will incorporate audits of PER forms and report back any concerns to the police custody suite to enable quick time learning. The Lay Observers (responsible for observing the escorting process) already audit PER forms and the IAP will meet with both organisations in 2012 to discuss whether these audits are bringing any marked changes in the accuracy of information contained in the PER form. The Independent Monitoring Board (IMB – responsible for monitoring the wellbeing of individuals in prison custody) was also consulted with to perform similar audits, although they thought this requirement went beyond their remit. Professor Shute will meet with the National Council of the IMB to identify a potential solution.

IAP 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, 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.

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**

**Government to establish office of the Chief Coroner**
On Tuesday 22 November 2011, the Government announced that it would not be abolishing the office of the Chief Coroner. Lord Toby Harris, Chair of the IAP welcomed the Government’s decision to establish the office of the Chief Coroner:

**IAP publish paper on delays to death in custody inquests**
On the 18 October 2011, Deborah Coles presented a paper to the Ministerial Board on delays to death in custody. The paper contained eight recommendations, which were accepted in principle by the Board. The IAP will now be identifying how to take these recommendations forward: [http://iapdeathsincustody.independent.gov.uk/news/iap-report-on-delays-to-inquests-into-deaths-in-custody/](http://iapdeathsincustody.independent.gov.uk/news/iap-report-on-delays-to-inquests-into-deaths-in-custody/)

**NICE guidance published on cardiovascular disease**
The National Institute for Health and Clinical Excellence (NICE) has re-issued their guidance on reducing the rate of premature deaths from cardiovascular disease and smoking-related diseases. This guidance aims to help NHS and other staff identify and provide services for people who are disadvantaged and most at risk of dying early from heart disease. The guidance was originally issued in September 2008 and was updated on 24 October 2011: [http://guidance.nice.org.uk/PH15](http://guidance.nice.org.uk/PH15)

**Chair of the IAP in the latest edition of The Solution**
Lord Toby Harris, Chair of the IAP, appeared on the October edition of the “The Solution” the online magazine for Black Mental Health UK and wrote the Forward, which focused on the significant amount of work still needed to be done to reduce the number of detained patients dying of natural causes in secure mental health settings: [http://free.yudu.com/item/embedded_reader/425171/The-Solution-issue-2?refid=64138](http://free.yudu.com/item/embedded_reader/425171/The-Solution-issue-2?refid=64138)

**Independent investigation into the case of ‘JL’ published**

**PPO report on learning from violence reduction and safety**

**HMIP publishes annual report for 2010/11**

**MoJ publishes reports made under Rule 43 of the Coroners Rules**
The Ministry of Justice (MoJ) published its summary of recommendations made by coroners between 1st October 2010 and 31st March 2011. It includes trends and reports with wider implications and annexes giving details of the numbers of reports issued by each coroner district, organisations who have neither responded to the coroner nor been granted an extension and all reports issued in this period. The report also has a small section relating to deaths in custody: [http://www.justice.gov.uk/publications/policy/moj/rule-43-responses-sept-2011.htm](http://www.justice.gov.uk/publications/policy/moj/rule-43-responses-sept-2011.htm)
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IAP Meeting 7 September 2011
The eleventh meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place on the 7 September 2011. At this meeting, the IAP discussed the latest collated summary of recommendations from Rule 43 Reports, their work on the statistical analysis of all recorded deaths between 2000 and 2010, progress on the six IAP working groups and an update on the evaluation of the Ministerial Council on Deaths in Custody. The Panel also heard from Nigel Newcomen, the new Prisons and Probation Ombudsman, who spoke about his plans for the PPO.

Nigel Newcomen, the new Prisons and Probation Ombudsman
In September, the Ministry of Justice announced that the Secretary of State for Justice, Kenneth Clarke, has appointed Nigel Newcomen CBE as the next Prisons and Probation Ombudsman for England and Wales: http://www.justice.gov.uk/news/press-releases/moj/moj-newsrelease050911.htm

Extension of corporate manslaughter law
The amended Corporate Manslaughter Act, which includes custody providers, namely prisons, secure hospitals, police, immigration detention centres and juvenile detention facilities, came into effect on 1 September 2011. The Government has also extended the law so that it will also apply to Ministry of Defence custody facilities and UK Borders Agency customs custodial facilities: http://www.legislation.gov.uk/ukpga/2007/19/contents

Call to action for suicide prevention in England
Samaritans have launched a consultation for national stakeholders about suicide prevention in England. They highlighted that suicide prevention requires action by many stakeholders across all sectors, as suicidal behaviour is related to many varied factors: http://www.samaritans.org/support_samaritans/campaigns/call_to_action_campaign_2011.aspx

People on remand
The Prison Reform Trust has published their latest report, entitled ‘Prisoners on Remand. The report highlights that remand prisoners have a range of mental health problems and according to the Office for National Statistics, more than three-quarters of men on remand suffer from a personality disorder: http://www.prisonreformtrust.org.uk/ProjectsResearch/Remand

Transfer from custody of young people under the Mental Health Act
The Department of Health published their protocols for transferring to and from hospital under the Mental Health Act 1983 any child or young person who is detained in custody in pursuance of any sentence or order for detention; or remanded in custody or who is otherwise detained in custody: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128853

Learning the Lessons Committee publish latest bulletin
The Learning the Lessons Committee produced its latest bulletin on lessons drawn from reports and information on investigations which the Committee receives from the Independent Police Complaints Commission (IPCC) on a regular basis. This bulletin explores learning from investigations into the police use of force in a variety of situations: http://www.learningthelessons.org.uk/Documents/LearningtheLessons_July2011_web_v6%20(2).pdf

Coventry University undertake restraint technique trials
The research on restraint techniques trials by Coventry University was published in the Medicine, Science and the Law, a Royal Society of Medicine journal. http://iapdeathsincustody.independent.gov.uk/news/coventry-university-undertake-restraint-technique-trials/
July edition of the IAP e-bulletin launched
The IAP published its fifth e-bulletin in July. This edition includes an update on the IAP statistical summary of all recorded deaths in state custody, the review of medical theories and research on restraint related deaths; the progress of the six IAP workstreams; details of the new IAP learning library; the family listening day for families affected by the death of a relative whilst detained under the mental health act and the evaluation of the Ministerial Council on Deaths in Custody.

Safety in Custody in England and Wales 2010
The Ministry of Justice and the National Offender Management Service (NOMS) published their annual statistical bulletin on deaths, self harm and violence in prison custody. The publication analyses deaths, self-harm and violence in prison custody, looking at trends across age, gender and time in prison custody. It also provides statistics relating to deaths in custody and assaults from 2001 to 2010 and self-harm in prison custody from 2004 to 2010 in England and Wales.

Department of Health launch suicide prevention consultation
The Department of Health launched a public consultation on their strategy to prevent suicide. The consultation sets out a proposal for a new suicide prevention strategy for England with the aims of reducing the suicide rate and improving support for those bereaved or affected by suicide. The consultation closed on 11 October and the result will be published on the Department of Health.
http://www.dh.gov.uk/en/Aboutus/Features/DH_128451

NCI publish report into suicide and homicide
The National Confidential Inquiry published their annual report on suicide and homicide by people with mental health covering the period between 1997 and 2008. The report found that during this time period, there were 56,091 deaths in the general population that were recorded as suicide or undetermined. http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/inquiryannualreports/Annual_Report_July_2011.pdf

Next Issue
The next issue of the e-Bulletin will be published in March 2012.