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Independent Advisory Panel on Deaths in Custody

Minutes of the Independent Advisory Panel (IAP) Meeting held on Wednesday 7th September 2011 in Conference Room 4, Clive House, 70 Petty France, London SW1H 9EX between 10.00am - 1:00 pm

Attendees: Lord (Toby) Harris of Haringey (Chair), Simon Armson, Deborah Coles, Dr Peter Dean, Professor Philip Leach, Professor Richard Shepherd, Professor Stephen Shute, Laura McCaughan (Head of Secretariat), Matt Leng (Deputy Head of Secretariat), and Alice Balaquidan (Minutes).

1. Welcome

The Chair welcomed the Panel members to the eleventh meeting of the Independent Advisory Panel (IAP) on Deaths in Custody.

2. Minutes of the Last Meeting

The Panel agreed that the minutes of the last meeting were an accurate record.

3. Matters Arising

(i) Rule 43 Reports Summary Table

Laura McCaughan reported that the latest collated summary of Rule 43 reports had been re-circulated to Panel members. She added that this would be updated on a regular basis, once additional reports were received. Where possible, the Secretariat had identified reports which had relevance for the Panel's workstreams and had flagged key learning points where there was no obvious link.

Deborah Coles thought that the length of delay between deaths and date of the Rule 43 report was revealing and that this mirrored her work on inquest delays. She welcomed the inclusion of deaths of patients detained under the Mental Health Act (MHA), especially those deaths where restraint had been identified as an issue. Stephen Shute asked whether the custody sectors' responses to the recommendations could be included in the table. Laura said that this could be done for prisons and Young Offender Institution (YOI) deaths, as the Secretariat were copied in to NOMS responses. However, this could not be done for the other custodial sectors at present.

The Chair believed it was important to circulate the product of this work as soon as possible, as it contained a rich source of potential learning. Although this piece of work would be more appropriately carried out by the MoJ in the longer term, he suggested sharing the summary table with custodial sectors whilst engaging with them about their

learning structures to identify how they respond to Rule 43 recommendations and change practices. **Action 1: Secretariat to share summary table with custodial sectors in discussion about their individual learning structures.** Stephen Shute believed the summary table would benefit from greater analysis to identify how recommendations were taken forward and how effective the learning mechanisms were within custodial sectors. Laura explained that this would be incorporated into the Rule 43 analysis project, which was due to be re-tendered by mid September. This work would sample a number of Rule 43 reports to evaluate the impact of recommendations on policy and practice both within and across sectors. The Panel would also be able to identify whether the learning mechanisms were effective and make recommendations for improvement. Deborah suggested that Panel members could identify pertinent cases from the table they would like included in the sample. **Action 2: Panel members to identify pertinent cases in the Rule 43 summary that could be sampled as part of the Rule 43 analysis.**

(ii) Coronial reform

The Head of Secretariat confirmed that coronial reform had been included on the agenda for this meeting under item 5.

(iii) Learning Governance in Custodial Sectors

Laura McCaughan informed the Panel that she had collected information from all sectors and relevant investigation bodies to outline their approach to and governance structures to support learning from deaths in custody. This had been presented on slides, to show the mechanisms for each custody sector, along with terms of reference of the individual committees and boards. Further information could be added as required, such as performance management and reporting mechanism. The Chair suggested that each of the committees and boards would be interested in the Rule 43 research and summary table. Philip Leach wondered how effective these structures were and believed there was value in asking a common set of questions on their governance arrangements, the approach to learning and how often they meet, as well as examples of agenda items and decision making responsibilities to understand their impact on deaths in custody. **Action 3: Secretariat to approach the various boards and committees with a series of common questions to examine their approach to learning from deaths in custody.**

(iv) Update on the Implementation of the Corporate Manslaughter and Homicide Act

The Head of Secretariat reported that Section 2.2 of the Corporate Manslaughter Act and Homicide Act 2007, which extended the Act to include deaths in custody, came into effect on 1 September 2011. Matt Leng had updated the paper he presented at the IAP meeting in May 2011 to reflect this, alongside additional information from Department of Health on their approach to preparation for implementation.

(v) IAP Members Visit to a Witness a UKBA Deportation Process

Matt Leng reported that he was negotiating with UK Border Agency (UKBA) about the roles and responsibilities of the Panel during the proposed visit to observe the deportation of immigration detainees. UKBA had suggested a series of dates for the

observation and it would be possible for Panel members to continue their observation of staff and detainees during the flight. The Chair stated that this would involve a substantial time commitment from the Panel members, given the likely destinations, and there would be no disembarkation from the flight until it returned to the UK. Both Peter Dean and Richard Shepherd believed there would be value in accompanying the flight, to see how the dynamic between staff and detainees changed once on board. The Chair invited the Panel to consider the dates on offer and to inform the Secretariat whether they wished to board the flight. **Action 4: Panel members to inform Matt Leng of suitable dates and whether they wished to board the flight.**

4. Statistical Analysis of all Recorded Deaths of Individuals Detained within State Custody

Matt Leng had circulated a draft copy of the statistical report to Panel members at the end of August, seeking their comments, which he had since incorporated. The Panel were grateful to Matt for his work on the draft and acknowledged that this was the first time the figures had been presented for all sectors over such a long period. The Panel discussed how to build on the analysis in the report, whilst ensuring it was based on evidence from the statistics available. Matt asked for further amendments to be submitted by email soon after the meeting to enable publication in early October. **Action 5: Panel members to send through suggested changes by email to the Secretariat.** Deborah Coles raised concern about using the term 'natural cause' for all deaths that were not self-inflicted and the Panel discussed their appetite for looking at more detailed classification of deaths to reflect the difference between those that could be viewed as preventable.

The Chair said that it was important to include as detailed an analysis as possible, to ensure the report included information about the context in which deaths occurred (e.g. population of prisoners or detained patients). The Panel made a number of other suggestions, including the importance of drawing out disproportionality of some figures and asked the Panel to suggest an appropriate academic contact to quality assure the final product. Professor Leach offered to ask a colleague at London Metropolitan University. **Action 6: Professor Leach to send a copy of the report to his colleague to provide quality assurance.** The Panel agreed that a statistical analysis should be published annually and would build on the depth of the analysis and evaluation of data.

5. Coronial Reform Update

The Chair stated that the Ministry of Justice's (MoJ) public consultation on the Public Bodies Bill was due to close on 11 October 2011. Both the Chair and Deborah Coles re-iterated the importance of the IAP continuing to support implementation of the role of Chief Coroner. However, given the government's proposals, the Panel would welcome further details about the proposed structures would provide a mechanism for standard setting, guidance and oversight of coroners. Peter Dean stated that whilst he would welcome the appointment of a Chief Coroner to improve the sharing of learning, he was concerned that unless more funding was made available to coroners, issues around workloads and inquest delays would continue.

Laura McCaughan said that she had prepared a draft response from the Panel to the consultation – with specific suggestions such as involving senior local authority officials on the Ministerial Board. She would circulate this again to the Panel for comments.

Action 7: Laura McCaughan to re-circulate the draft response to the Public Bodies Bill consultation to Panel members.

6. Summary of Actions and Preparation for the Ministerial Board on 18 October 2011

Laura McCaughan reported that the next Ministerial Board meeting would be chaired by Nick Herbert MP, Minister of State for Policing and Criminal Justice. She added that officials from Coroners and Burial Unit (CBU) had agreed to attend to discuss recommendation eight of Professor Leach's Article 2 paper. They would also present a paper outlining the government's proposals for reform of the coroner system. Deborah Coles was due to present a paper on delays in death in custody inquests, which would include recommendations to the MoJ.

The Panel were due to update the Board on progress in relation to assessing provision for places of safety under Section 136 of the MHA, along with an update from Professor Shute on the development of the information sharing statement and his work on the Person Escort Record (PER) form as well as Professor Shepherd's response to the research on medical theories of restraint.

7. Update from Panel Members on Workstreams

(i) Use of Physical Restraint

Richard Shepherd reported that the draft review of the medical theories and research relating to restraint deaths (due for presentation at the next Ministerial Board) had been peer reviewed and that the initial comments were positive. However, he highlighted that one of the comments suggested that the phenomena of excited delirium should be separated from the reference to acute behavioural disturbances to prevent it being presented as one condition.

Deborah Coles believed that the review provided a good overview of the medical theories; however she suggested that the issue of the disproportionate number of individuals from a Black and Minority Ethnic (BME) group who died following restraint would require further analysis. Deborah would send further comments to Matt Leng.

Action 8: Deborah Coles to send comments on the restraint report to Matt Leng. The Chair explained that there would be an accompanying paper to highlight how the Panel intended to use the report for its future work on restraint. **Action 9: Secretariat to produce a short paper for the Board in October 2011 outlining areas in the report the Panel wished to take forward.**

(ii) Risks Relating to Transfer and Escorting of Detainees

Peter Dean reported that he had recently attended a meeting of the Association of Chief Police Officers (ACPO) National Mental Health Forum, where he had presented his findings on Section 136 of the MHA. Attendees welcomed his presentation and echoed the same concerns around finding adequate places of safety for Section 136 detainees. It was agreed that a meeting with the IPCC, Care Quality Commission (CQC), Home Office, Department of Health (DH), Royal College of Psychiatrists, Association of Chief Police Officers (ACPO) and INQUEST should be organised to discuss issues around the funding and staffing of places of safety and to identify any further gaps. This would help provide an evidence base to the next Ministerial Board meeting in February 2012.

(iii) Article 2 Complaint Investigations

Philip Leach reported that he had presented his paper to the Ministerial Board in June 2011, and that the majority of the recommendations were accepted in principle. He had subsequently held a meeting with the Youth Justice Policy Unit in the MoJ, Youth Justice Board (YJB), Prisons and Probation Ombudsman (PPO) and Ofsted to discuss his recommendation that the PPO should investigate deaths in secure children's homes. The Department of Education (DfE) were unable to attend the meeting but they had indicated that they were content to consider the recommendation. The PPO had also sent feedback on the timeliness of clinical reviews in the previous quarter, which showed a downturn in delivery.

Philip added that he was due to meet Louis Appleby alongside Simon Armson to discuss the number and quality of investigations of deaths of detained patients. He would provide an update to the Panel on this activity at the next meeting in December 2011.

(iv) Cross Sector Learning

Deborah Coles' report on inquest delays had been agreed with the Honorary Secretary of the Coroners' Society for England and Wales. She would be circulating the report to relevant members of the practitioner and stakeholder group and Panel for their comments in advance of presentation to the Ministerial Board in October 2011. It provided a helpful overview of the extent of delays as well as the main reasons behind them. Deborah explained that these included the disproportionate number of custodial settings in some coroner districts; waiting for investigations undertaken by other agencies; difficulties with securing dates for witnesses to attend and finding appropriate accommodation in which to hear the inquest.

Laura McCaughan informed the Panel that a new invitation to tender for an analysis of the impact of Rule 43 reports had been agreed. The tender was due to go out in mid September 2011 and the expected date of award was mid October 2011. Deborah added that recommendations from this work would probably include some suggestions for improving custody sectors learning mechanisms to ensure they use valuable learning from Rule 43 reports and narrative verdicts.

(v) Information Flow through the Criminal Justice System (CJS)

Stephen Shute had presented his paper and recommendations to the Board in March 2011. He informed the Panel that the recommendation to amend Prison Service Order (PSO) 4630 was complete which would make it mandatory for discharging prisons to send core records of time served prisoners with them when they are transferred to Immigration Removal Centres. .

The recommendation to develop clear and concise national cross sector guidance on information sharing had also been taken forward. In May 2011, he had held meetings with officials from NOMS, ACPO, UKBA and YJB where it was agreed that a simple statement would be developed by the Panel for practitioners in the custodial sectors reminding them of the importance of sharing of information relating to self-harm / suicide to provide a continuity of care for an individual. This had been presented to the Information Commissioner in July 2011, who endorsed the statement. In terms of next steps, he would be looking for further endorsement from the General Medical Council

before circulating to the custodial sectors for their input. An update on this work would be presented to the Board in October 2011.

The recommendation on quality assuring a sample of Person Escort Record (PER) forms was also being taken forward. A meeting with NOMS and ACPO had been held in May 2011 where it was agreed that a more substantial evidence base was needed to assess whether the information on the PER was being accurately recorded and shared. Stephen met with Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Constabulary (HMIC) who have agreed to identify a sample of between 20-50 cases during two inspections where a PER had been completed by the police force being inspected and where the detainee subsequently moved to prison to review what information relating to suicide / self-harm from the police completed PER appears on P-Nomis. This would help assess the consistency and accuracy of the information being shared. In parallel, the Independent Custody Visitors Association (ICVA) and Lay Observers had agreed to incorporate reviews of the PER forms during their visits and to report any concerns back to the appropriate establishment. He was still in dialogue with the Independent Monitoring Boards (IMB) to see if they would be willing to undertake similar reviews.

(vi) Death of Patients Detained under the Mental Health Act (MHA)

Simon Armson stated that an update had been provided to the Board in June 2011 on the progress of the five recommendations he presented in March. These had focussed primarily on CQC and Department of Health (DH). He had attended meetings with both organisations, although these had not been as conclusive as he would have liked and dialogue was ongoing with CQC and DH to drive forward the recommendations. Simon added that CQC were currently undergoing internal restructuring on their MHA monitoring function. The Chair had agreed to write to Dame Jo Williams, Chair of the CQC to organise a meeting to discuss some of these issues, which would hopefully enable them take forward recommendations about collecting and analysing data on the reasons for high number of deaths from physical ill health.

A positive meeting had been held in July 2011 with Geraldine Strathdee, a consultant psychiatrist at Oxleas NHS Foundation Trust who has also has for mental health at NHS London. Geraldine provided constructive insight on the recommendations and also provided her view on how the Panel might re-define the approach to 'natural cause' deaths. Simon noted that his workstream was not confined to deaths of patients detained under the Act but there would be learning for detainees with mental health problems in all custodial settings that would inform his future work.

Simon would be working with Philip on potential research into the quality of investigations of deaths of detained patients, including the meeting with Professor Louis Appleby.

8. Strategic Planning for IAP's Work Priorities and Update Ministerial Council Evaluation

Laura McCaughan reported that as part of the evaluation of the Ministerial Council, the Secretariat had written to members of the Practitioner and Stakeholder Group, Ministerial Board members and Panel members to seek their views on the effectiveness of the current arrangements. She had received 13 responses from 50 letters and whilst this rate was low, they represented a wide variety of stakeholders and that the feedback had been positive and constructive. The feedback would be

incorporated into a submission, which was due to be sent to Ministers in November 2011. A Ministerial decision on the continuation of the Council was likely to be received in December 2011.

The Chair suggested that due to time constraints at the meeting, strategic planning for the IAP's future work should be included as an agenda for the next IAP meeting on 7 December 2011. **Action 10: Secretariat to include strategic planning for the IAP's future work on the agenda for the 7 December 2011 meeting.**

9. Deaths in Immigration Removal Centres and in Police Custody

The Chair highlighted that there had been three deaths in or following police contact in August 2011, which involved the use of Tasers and / or PCVA (pepper) spray. He added that the IPCC were currently investigating these deaths and that it might be helpful to look at the outcome of these cases in order to identify any potential learning.

Deborah highlighted a recent death in London where she believed there were a number of lessons to be learned, particularly around family liaison. The Chair acknowledged Deborah's concerns and suggested that a meeting should be set up between the Panel and the Independent Police Complaints Commission (IPCC). The purpose of this would be to identify what mechanisms are in place for handover between police and IPCC family liaison. **Action 11: Secretariat to write a letter from the Chair to the IPCC to organise a meeting to discuss family liaison policies.**

The Chair also drew the Panel's attention to three recent deaths in the immigration detention estate. The Chair believed that a roundtable meeting with UKBA, Her Majesty's Inspectorate of Prisons (HMIP) and the Independent Chief Inspector of UKBA would be of value to identify any emerging themes or common factors in these deaths. **Action 12: Secretariat to organise a roundtable meeting involving UKBA, HMIP and the Independent Chief Inspector of UKBA.**

10. Any Other Business

There was no other business from Panel members.

11. Date, Time and Venue of Next Meeting

The Chair confirmed that the next IAP meeting would be held on the 7 December 2011 between 10.00am and 1.00pm in Conference Room 3 in Clive House.

Summary of actions

	Action from 7 September 2011	Progress
1	Secretariat to share summary table with custodial sectors in discussion about their individual learning structures.	Outstanding
2	Panel members to identify pertinent cases in the Rule 43 summary that could be sampled as part of the Rule 43 analysis.	Outstanding
3	Secretariat to approach the various boards and committees with a series of common questions to examine their approach to learning from deaths in custody.	Outstanding
4	Panel members to inform Matt Leng of suitable dates and whether they wished to board the flight.	Done
5	Panel members to send through suggested changes to the statistics report by email to the Secretariat.	Done
6	Professor Leach to send a copy of the report to his colleague to provide quality assurance.	Done
7	Laura McCaughan to re-circulate the draft response to the Public Bodies Bill consultation to Panel members.	Done
8	Deborah Coles to send comments on the restraint report to Matt Leng	Done
9	Secretariat to produce a short paper for the Board in October 2011 outlining areas in the report the Panel wished to take forward.	Done
10	Secretariat to include strategic planning for the IAP's future work on the agenda for the 7 December 2011 meeting.	Done
11	Secretariat to write a letter from the Chair to the IPCC to organise a meeting to discuss family liaison policies.	Done
12	Secretariat to organise a roundtable meeting involving UKBA, HMIP and the Independent Chief Inspector of UKBA.	Done