

## **PROGRESS REPORT ON THE SIX WORKING GROUPS BEING TAKEN FORWARD BY THE INDEPENDENT ADVISORY PANEL (IAP) ON DEATHS IN CUSTODY**

The terms of reference for the IAP's six working groups were approved at the Ministerial Board in October 2009 and the initial scoping work for all of the groups is underway. This paper reports on the emerging findings and provides some preliminary recommendations from the groups considering the issues of the use of physical restraint and cross sector learning. It should be noted that the work of both of these groups is at an early stage with the evidence-gathering phase still underway, however the IAP wanted to gauge the Board's views on the suggested direction of these initial recommendations. If supported by the Board, the next stage of this work will be to undertake further consultation with stakeholders to determine the most effective way of taking these recommendations forward.

This paper also provides an update on the progress of the four other working groups, which are exploring the issues of information flow through the Criminal Justice System (CJS), 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. Some emerging findings from these groups are due to be presented and discussed at the Board in June 2010.

### **The Use of Physical Restraint Working Group**

#### **Background**

The aim of this group, led by Professor Richard Shepherd, is to:

- Review the statistics on the number of restraint related deaths that have occurred within state custody over the last ten years
- Identify the points of correlation and discrepancies between custody sectors in relation to the policies and guidance governing the use of restraint and training provided to staff
- Undertake a short review of medical theories relating to restraint
- Identify good practice and whether cross sector guidance would be useful in relation to the use of restraint

In order to inform the work of this group, the IAP commissioned the Offender Health Research Network (OHRN), a research collaboration between the Universities of Manchester, Oxford, York and Bristol and the Institute of Psychiatry to review the literature and current policies associated with restraint across the different custody sectors.

Additionally, meetings have been held with key stakeholders from the Department of Health, the National Offender Management Service (NOMS) and the Metropolitan Police to identify the variety of techniques and principles each custody sector adopts in relation to the use of restraint and whether there are common approaches to this.

### **Statistics on the Number of Restraint Related Deaths within State Custody**

The table overleaf provides an overview of the number of deaths that have occurred in state custody between 1999 and 2008 where restraint was a direct feature of the death. It should be noted that the IAP were unable to obtain data on the number of restraint related deaths (if any), which occurred in or following police custody between 2000 and 2003 so the figures could be under reported. Further work will be undertaken by the IAP to obtain this data.

**Table 1. The number of deaths of individuals in state custody where restraint was a direct feature of the death between 1st January 1999 - 31st December 2008**

Custodial sector	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Prisons	0	0	0	0	0	0	1	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-
21-30	-	-	-	-	-	-	1	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>
Secure Young People's Estate*	0	0	0	0	0	1	0	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	1	-	-	-	-
21-30	-	-	-	-	-	-	-	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Immigration Removal Centres	0	0	0	0	0	0	0	0	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-
21-30	-	-	-	-	-	-	-	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-
41-50	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>0</b>									
Police**	2	-	-	-	-	2	0	1	0	0
Age breakdown	-	-	-	-	-	N/A	-	N/A	-	-
11-20	-	-	-	-	-	-	-	-	-	-
21-30	1	-	-	-	-	-	-	-	-	-
31-40	-	-	-	-	-	-	-	-	-	-
41-50	1	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>
Secure Mental Hospitals	0	0	0	1	1	2	0	1	0	0
Age breakdown	-	-	-	-	-	-	-	-	-	-
11-20	-	-	-	-	-	-	-	-	-	-
21-30	-	-	-	-	1	1	-	-	-	-
31-40	-	-	-	1	-	1	-	1	-	-
41-50	-	-	-	-	-	-	-	-	-	-
51-60	-	-	-	-	-	-	-	-	-	-
61-70	-	-	-	-	-	-	-	-	-	-
71-80	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>
<b>Total restraint related deaths in state custody in England and Wales</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>5</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>0</b>
<b>Total deaths in state custody for England and Wales</b>	<b>648</b>	<b>607</b>	<b>562</b>	<b>512</b>	<b>566</b>	<b>582</b>	<b>561</b>	<b>554</b>	<b>550</b>	<b>526</b>

**Notes:**

\* Young people are accommodated in a number of different establishments, depending on their age. Secure Children's Homes (SCH) are generally used to accommodate young offenders aged 12 to 14, girls up to the age of 16, and 15 to 16-year-old boys who are assessed as vulnerable. Secure Training Centres (STCs) are purpose-built centres for young offenders up to the age of 17. They are run by private operators under contracts, which set out detailed operational requirements and Young offender institutions (YOIs) are facilities run by both the Prison Service and the private sector and can accommodate 15 to 21-year-olds.

\*\* The data provided by the IPCC covers the period from 2004 to 2009 only. The IPCC are conducting an in depth analysis of deaths in police custody over the 10 year period, and the IAP will use this to feed into the Ministerial Council baseline statistics. Details of the two deaths in 1999 - Roger Sylvester and Glenn Howard - were provided to the IAP by INQUEST.

**Data sources:**

Prisons and Probation: National Offender Management Service  
 Police: Independent Police Complaints Commission  
 Immigration Removal Centres: UK Borders Agency  
 Secure Young People's Estate: Youth Justice Board  
 Secure Mental Hospitals: Care Quality Commission

Between 1999 and 2008, there were 5,668 deaths in state custody, of which 12 were as a direct result of restraint. As a proportion of total deaths in custody, restraint related deaths remain low with 1 in every 472 deaths occurring as a direct result of this. From the available data, we found that:

- 1 in every 2 deaths occurred whilst the individual was either detained under the Mental Health Act (MHA) or in police custody
- Out of the 12 deaths, 9 of these were males. However, no gender breakdown has been provided for the deaths, which occurred in police custody in 2004 and 2006 so the figures will change once this data is obtained.
- 5 out of the 12 deaths were individuals from Black and Minority Ethnic (BME) groups, with 3 classified as Black, 1 as Asian and 1 as mixed ethnicity. Two were classified as White British. The ethnicity of the remaining 5 individuals is unknown and as a result the number of those that died from BME groups could be under reported here. Four out of these 5 deaths occurred within police custody and 1 whilst the individual was detained under the MHA so further work is required to obtain this information from the Independent Police Complaints Commission (IPCC) and the Care Quality Commission (CQC)
- 7 of those who died were between the ages of 21-40

Despite the numbers being relatively low, these deaths are among the most contentious and high profile for the custody sectors involved because they have all, by definition, occurred directly at the hands of another. There are also a number of common themes with these cases including positional asphyxia and excited delirium, which have relevance from a learning perspective for all of the custody sectors.

The figures in the table above, only take into account the deaths, which occurred as a direct result of restraint. The IAP recognises that there is a gap here, as by only focussing upon the deaths where restraint was a direct cause, we ignore a vital evidence base of deaths where restraint was deemed to be a contributory factor. There is a large amount of potential learning that could be extrapolated from these. As a result, the IAP recommends undertaking a review of all Rule 43 Reports, narrative verdicts and investigation reports produced by the Prison and Probation Ombudsman (PPO), the Independent Police Complaints Commission (IPCC) and the Care Quality Commission (CQC) relating to those deaths where restraint was identified as a contributory factor, as well as a direct cause. The Panel recognises that Coroners and the investigative bodies have made a large number of recommendations in relation to the use of restraint, which could be used to inform this learning. The aim of this work will be to identify any trends particularly in relation to ethnicity and mental health and relevant learning for dissemination across the custodial sectors.

**RECOMMENDATION 1: The IAP 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, as well as a direct cause in order to highlight any trends particularly in relation to ethnicity and mental health.**

## **Policies and Guidance relating to the Use of Restraint**

The IAP conducted an initial scoping exercise, which provided an overview of how each of the custodial sectors approaches the use of physical restraint. This exercise highlighted the lack of a common definition of the term 'restraint', given the wide variety of challenges present in each sector surrounding this issue. These differences are affected by the operational environment, circumstances of the detainee and the level of training received by staff. A correct approach to restraint deployed by a police officer may not be the correct approach in a prison cell, although from our discussions with key stakeholders there appears to be a common "final pathway" when the physical "hands on" restraint is applied.

The role of the police as an emergency service poses different challenges, given that they will often have to deal with an unpredictable situation. Police officers may have very limited intelligence on the individual upon restraint and arrest. Staff in secure hospitals face different challenges, posed by the individuals detained in their establishments, and as such, are subject to different training regimes. Within the NHS, focus is placed on the therapeutic care of the patients, and restraint techniques - adopted by secure hospitals in the mid 1980's - have been modified to take this into account.

The Panel did find examples of commonality across the custodial sectors in approaching the use of physical restraint. Guidance<sup>1</sup> for staff who may be expected to use restraint states that it should be used as a last resort, in attempting to control a violent individual, and when used, staff must be able to show that the use of force adheres to the principles of necessity, reasonableness and proportionality. Staff from all of the custodial sectors are trained in the first instance to prevent and manage violence through utilising non-

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<sup>1</sup> Association of Chief Police Officers (ACPO) *Personal Safety Manual of Guidance, Prison Service Order (PSO) 1600* – which governs both prisons and Immigration Removal Centres, National Institute for Health and Clinical Excellence (NICE), *The Short Term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments* and *YJB Codes of Practice for Managing the Behaviour of Children and Young People in Secure Settings*.

physical interventions, and verbal de-escalation techniques in order to defuse tension and prevent loss of control.

The need for a more coherent approach to the issue of safer restraint with greater co-ordination between government departments and across services was a key recommendation in the Police Complaints Authority (PCA) Safer Restraint conference report<sup>2</sup> (2002) and the IAP strongly endorses this. The Panel is planning to undertake further analysis of the information obtained to date, with a view to developing a set of common principles, to which the custodial sectors should all adhere as a minimum. 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, the use of equipment such as mechanical restraints, handcuffs and batons and recovery procedures following the use of restraint including the involvement of healthcare staff.

The IAP found examples which indicated that the custodial sectors are sharing lessons in relation to the use of restraint. HM Prison Service is for example in the process of considering the implications of the recommendations of the independent review of restraint in juvenile secure settings for the wider prison estate. Similarly, as outlined below, the Self Defence, Arrest and Restraint Group (SDAR) led by the Association of Chief Police Officers (ACPO) shows further evidence of cross sector work in this area. However, more needs to be done and the IAP recommends holding a high-level workshop with the training leads from each of the custody sectors to identify the themes and common approaches to restraint techniques and examples of good practice, which can feed into the development of the common principles outlined above. One of the main aims of this workshop will be to encourage further joined up working between the different sectors. Attendee's from the Department of Health, the NHS, NOMS, the Metropolitan Police Service (MPS), Welsh Assembly Government and the Joint Youth Justice Unit will be invited to ensure a broad representation from all of the custody sectors.

The Self Defence, Arrest and Restraint Group (SDAR) serves to inform and advise on all personal safety matters within the Police Services of England and Wales. The membership of this group includes representatives from HM Prison Service and the UK

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<sup>2</sup> Police Complaints Authority (2002) *Safer Restraint – Report of the Conference held in April 2002 at Church House, Westminster*. London: The Police Complaints Authority.

Border Agency because of the implications for their work, but currently there is no health representation. The main focus of this group is on restraint in the context of officer safety and the IAP is mindful that the safety of both staff and the detainee must be a central concern to work undertaken in this area, given the State's positive duty of care to its employees and also the need to protect every individual's fundamental right to life. As a result, the IAP recommends that consideration should be given to the benefits of establishing a new high level cross sector group, which has sufficient weight to formalise and encourage interagency co-operation and planning and to disseminate information and good practice. The viability and benefits of establishing such a group should be explored further at the workshop with training leads.

**RECOMMENDATION 2: The IAP 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.**

**One of the aims of this workshop would be to determine the viability and benefits of establishing a new high level cross sector group to share good practice in relation to the use of restraint.**

## **Medical Theories**

There are a number of different medical theories addressing why some people die following restraint and significant debate still surrounds the subject. With regards to research evidence, two commonly cited concepts are positional asphyxia and excited delirium. It should be noted that a greater awareness of positional asphyxia and excited delirium has resulted in changes to policy, practice and training for staff.

Positional or postural asphyxia occurs when respiration and therefore oxygenation is impaired due to the accidental positioning and fixation of the person's body (Padosch et al., 2005<sup>3</sup>; Byard et al., 2008<sup>4</sup>) so that their breathing is limited. The resulting asphyxia takes place because the victim is unable to remove themselves from this impeding position. There are numerous reasons why an individual may find themselves in this type of position, including intoxication, sedation, organic disease e.g. multiple sclerosis,

<sup>3</sup> Padosch SA, Schmidt PH, Kroner U, Madea B. 2005. *Death due to positional asphyxia under severe alcoholisation: Pathophysiologic and forensic considerations*. Forensic Science International 149: 67-73.

<sup>4</sup> Byard RW, Wick R, Gilbert JD. 2008. *Conditions and circumstances predisposing to death from positional asphyxia in adults*. Journal of Forensic and Legal Medicine 15: 415-19.

chronic injury/quadruplegia or a combination of the above (Byard et al., 2008<sup>5</sup>). Or it may be that they are restrained in a position where breathing is obstructed. Similarly, a number of factors may render the person unable to rescue themselves from an asphyxiating position such as intoxication, neurological impairment/disease, loss of consciousness, physical impairment or physical exhaustion. Or they may be prevented from doing so by physical restraint (Byard et al., 2008<sup>6</sup>).

Excited delirium is a rare condition most commonly associated with cocaine abuse that is characterised by disturbances of cognition, perception and attention with disorganised thinking, memory impairment and defective orientation (Wetli, 2005<sup>7</sup>). The features of delirium include agitation, excitability, paranoia, aggression, great strength, numbness to pain and elevated body temperature (Paquette, 2003<sup>8</sup>; Marsh et al., 2009<sup>9</sup>);. These individuals are a risk to themselves and others and will require restraint. Excited delirium renders them at great risk of sudden collapse and death at any time and the risks of restraint are very greatly increased.

To inform the work of this group, the Offender Health Research Network (OHRN) undertook a short review of the current medical theories surrounding restraint related deaths. However, given the amount of debate concerning this issue and the lack of consensus among pathologists and other medical practitioners as to the precise cause of death in many restraint related cases, the IAP recognises that further analysis of the evidence base is required. The Panel recommends that a meta-analysis of the medical theories and research relating to restraint related deaths, with particular reference to excited delirium and positional asphyxia is undertaken in order to identify common themes and key learning points for dissemination across the custodial sectors. The findings of this work will also enable the IAP to identify a number of fundamental principles in relation to the dangers associated with excited delirium and positional asphyxia and evaluate whether these are adequately covered by the current training packages used by each of the custodial sectors.

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<sup>5</sup> As Above

<sup>6</sup> As Above

<sup>7</sup> Wetli CV. 2005. Excited Delirium. Encyclopedia of Forensic and Legal Medicine, 276-281. Elsevier: Academic Press.

<sup>8</sup>Paquette M. 2003. *Editorial - Excited Delirium: Does it Exist?* Perspectives in Psychiatric Care 39 (3): 93-4.

<sup>9</sup> Mash DC, Duque L, Pablo J, Qin Y, Adi N, Hearn WL. et al. 2009. *Brain Biomarkers for Identifying Excited Delirium as a Cause of Sudden Death*. Forensic Science International 190: 13-19.

The results of Recommendation One, which highlights the need for a review of Rule 43 Reports, narrative verdicts and investigation reports relating to those deaths where the use of restraint was identified as a contributory factor, as well as a direct cause will also help to inform and strengthen this work. It would also be helpful to hold an expert seminar to feed into this study, as there are a number of members of the Practitioner and Stakeholder Group including medical practitioners and legal experts who have worked around this issue for many years and can offer significant expertise.

The presence of an underlying health condition has been frequently cited as contributing to death following restraint (Stratton et al., 2001<sup>10</sup>; Sathyavagiswaren et al., 2007<sup>11</sup>; Byard et al., 2008<sup>12</sup>; Jauchem, in press<sup>13</sup>). Two of the conditions that have been associated with restraint related death are Chronic Obstructive Pulmonary Disease (COPD) and Sickle Cell Disease (SCD), this is of particular importance as it is an inherited blood disorder that mainly affects people of African or Caribbean origins. The evidence in relation to these theories should also be explored further as part of this study. Professor Richard Shepherd who is leading this group on behalf of the IAP will work with the Secretariat to develop a research proposal.

**RECOMMENDATION 3: IAP to commission a meta-analysis of the medical theories and research relating to restraint related deaths including excited delirium and positional asphyxia in order to identify common themes and key learning points for dissemination across the custodial sectors. An expert seminar will be held to feed into the development of this work.**

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<sup>10</sup> Stratton SJ, Rogers C, Brickett K, Gruzinski G. 2001. *Factors Associated With Sudden Death of Individuals Requiring Restraint for Excited Delirium*. American Journal of Emergency Medicine 19 (3): 187-91.

<sup>11</sup> Sathyavagiswaran L, Rogers C, Noguchi TT. 2007. Restraint asphyxia in in-custody deaths Medical examiner's role in prevention of deaths. Legal Medicine 9: 88-93.

<sup>12</sup> Byard RW, Wick R, Gilbert JD. 2008. *Conditions and circumstances predisposing to death from positional asphyxia in adults*. Journal of Forensic and Legal Medicine 15: 415-19.

<sup>13</sup> Jauchem JR. In press. *Deaths in custody: Are Some Due to Electronic Control Devices (including TASER devices) or Excited Delirium?* Journal of Forensic and Legal Medicine.

## **Cross Sector Learning Working Group**

### **Background**

The aim of this group, led by Deborah Coles is to:

- Identify the current investigative procedures employed by custodial sectors following a death in custody
- Determine how the different custody sectors capture and share learning in relation to deaths in custody
- Identify the processes for the collation and dissemination of Rule 43 Reports and narrative verdicts and
- Collect data on the number of deaths in custody awaiting inquests and undertake a short analysis of this data to ascertain the reasons for the delays

In order to inform the work of this group, a series of meetings have been held with key stakeholders to identify and discuss the priorities in relation to cross sector learning from a mental health and prisons/policing perspective. The organisations represented at these meetings included the Department of Health, Care Quality Commission (CQC), HM Inspectorate of Prisons, Independent Police Complaints Commission (IPCC), Youth Justice Board (YJB), Ofsted, the Prisons and Probation Ombudsman (PPO) and the Coroners Society. These have been helpful in bringing together organisations that had not previously engaged in discussions despite having a shared interest in preventing deaths in state custody. A meeting with a small group of Coroners was also held to discuss how cross sector learning could be improved from a coronial perspective. Meetings with representatives from the National Patient Safety Agency (NPSA) and the Crown Prosecution Service (CPS) are also in the process of being organised.

### **Investigative Procedures and How Learning is Captured and Disseminated**

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.

Another issue highlighted during the consultative meetings was the need for more robust mechanisms to ensure that action plans are produced following a death in custody, that these are regarded as live documents and regularly reviewed to ensure that all of the recommendations are implemented. Again, the IAP is aware that there are written policies in place in relation to this, but needs to obtain examples to demonstrate how these policies are being utilised in practice.

**RECOMMENDATION 4: IAP 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.**

#### **Collation and Dissemination of Rule 43 Reports and Narrative Verdicts**

The Coroners and Burials Division within the Ministry of Justice (MoJ) now has responsibility for collating Rule 43 Reports and responses received by the Lord Chancellor, which is welcomed by the IAP. However, an issue highlighted at the meeting held with Coroners was that the collation of these documents was only the first step. It was argued that sufficient analysis of both the recommendations in order to identify key learning points, which had relevance for all of the custodial sectors and the responses in order to identify if organisations were addressing these recommendations was required.

The IAP have conducted a scoping exercise to obtain a snapshot of how the different custody sectors collate and disseminate Rule 43 Reports and narrative verdicts, which highlighted varying levels of effectiveness. There was a gap identified in relation to the

police, as both ACPO and the National Policing Improvement Agency (NPIA) do not receive Rule 43 Reports as a matter of course. Whilst each individual police force receives and responds accordingly to the Rule 43 Reports relevant to them, in terms of sharing the learning from these reports on a national level most forces would rely on the lessons learnt bulletin from the Independent Police Complaints Commission (IPCC) and any recommendations from HMIC/HMIP inspection reports. These recommendations however, would be specific to a particular force and would not necessarily be picked up instantaneously by all 43 forces. The IAP felt that there could potentially be more of a role for ACPO and the NPIA in the national dissemination of lessons following a death in or following police custody and that this should be explored further.

The IAP found that with the exception of NOMS, the other custodial sectors tended to focus their attention on Rule 43 recommendations and did not reference in any detail how they collected, collated and derived specific learning from narrative verdicts, despite these highlighting valuable lessons.

A concern for the IAP is that learning from deaths in state custody must be made a higher priority. The appointment of the new Chief Coroner provides an opportunity to do this. The IAP recommends that the remit of the new Chief Coroner contain a specific reference to learning from deaths in state custody. A key responsibility of this role will be to issue national guidance and standards. The IAP recommends at some stage that guidance is produced on Article 2 cases, which recognises the particular role of the inquest following a death in custody in establishing any lessons to prevent similar fatalities. Approaches to the Coroners and Burials Division in the MoJ have already been made and the Chair of the IAP will be pursuing this issue with them over the coming months.

**RECOMMENDATION 5: That a specific reference to learning from deaths in state custody is included within the remit of the new Chief Coroner.**

Additionally, the IAP recommends that the new Chief Coroner once appointed in 2010 is invited to sit on the Ministerial Board, given the relevance of the issues discussed at the Board for this role.

**RECOMMENDATION 6: That the new Chief Coroner is invited to sit on the Ministerial Board on Deaths in Custody.**

The inconsistency of the format and content of Rule 43 Reports was highlighted as an issue at the meeting held with Coroners. 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 main aim of these guidelines would be to ensure that a number of minimum requirements were met so that they were as helpful as possible from a learning perspective and standardise the composition to assist with analysis. The IAP strongly endorses this approach, but recognises that the guidelines would need to be written in such a manner as to not compromise the independence of Coroners in any way.

**RECOMMENDATION 7: That guidance is developed specifically for Coroners to assist them with the production of Rule 43 Reports.**

#### **Data on the Number of Deaths in Custody Awaiting Inquests**

The IAP recognises that delays to inquests not only have an enormous impact upon the family and staff involved, but can also diminish the relevance of any learning. The meeting held with coroners highlighted a number of reasons why inquests can be delayed, which 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;
- 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 IAP acknowledges that further work is required to obtain accurate figures on the numbers of outstanding inquests into deaths in state custody and the reasons for these

delays. The Secretariat are in the process of developing a questionnaire to send to individual Coroners to obtain data on the number of inquests, which are currently outstanding for more than a year and further details on the reasons for this. The aim of this work is to gain a better understanding of which parts of the country have a particular backlog of death in custody inquests; whether particular Coroners have a disproportionate number of custody cases; and the number of cases where the PPO report has been received by the Coroner, but the inquest has still not been listed. The IAP is keen to take this work forward in conjunction with the Coroners Society in order to maximise support from Coroners and will explore this further outside the Board. The Secretariat will analyse the results of this questionnaire with a view to developing a series of recommendations to reduce these delays.

**RECOMMENDATION 8: The IAP 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 these delays**

### **Update on the IAP's Other Working Groups**

An update on the progress of the IAP's four other working groups are provided below. Much of this work is ongoing and will continue to develop over the coming months. The IAP is aiming to present some preliminary findings from each of these groups at the next Board meeting in June 2010.

### **Deaths of Patients Detained under the Mental Health Act (MHA) Working Group**

In order to inform the work of this group, the Offender Health Research Network (OHRN) have been commissioned to undertake the following work on behalf of the IAP (this work is due for completion at the end of February 2010):

- Conduct a scoping review of the literature around the subject and access reports and inquiries into such deaths over the last ten years
- Produce a thematic overview of the findings and recommendations of these reports
- Liaise with the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCI), which has an ongoing work programme on in-patient deaths in mental health settings

- From the NCI data, identify a sub-set of deaths amongst formally detained patients and then identify any key features and identifiable differences between the deaths of those detained under mental health legislation compared to informal patients

Meetings have taken place with the Chair and Head of Mental Health Operations at the Care Quality Commission (CQC) and representatives from the Mental Health Unit and Offender Health within the Department of Health to gauge their views on the priorities for this working group. Members of the IAP have visited Broadmoor high secure hospital and are planning to visit a medium and low secure mental health ward. The Secretariat has worked with the CQC to address the gaps identified at the first Ministerial Board in relation to the data on the deaths of those detained under the Act and attempts are being made to obtain copies of all of the Rule 43 Reports relating to these deaths in order to identify relevant learning from these.

## **Article 2 Complaint Investigations Working Group**

There is a significant overlap between the issues being explored by this group and the working group considering the issue of cross sector learning. The Panel members leading these groups are working together as a result. A number of meetings have been held with key stakeholders, as outlined in the cross sector learning section of this paper. These meetings have highlighted a number of issues for the IAP to explore further in relation to Article 2, which include:

- The level of independence of clinical reviews undertaken as part of a PPO investigation, when they are often undertaken by the Primary Care Trust (PCT) responsible for commissioning and/or providing the healthcare services under review
- The difficulties faced by some Coroners when trying to balance coronial commitments for Article 2 investigations, alongside their regular workload
- A lack of clarity around the requirements for investigations into near deaths
- The level of Article 2 compliance of the investigation regime for deaths in mental health settings

## **Information Flow through the Criminal Justice System Working Group**

The OHRN have produced a paper for this group, which describes how risk information is shared through the offender pathway and highlights the obstacles and barriers that impede data flow within the Criminal Justice System (CJS). This paper is currently being analysed by the IAP and will be used to inform the direction of the group's work. The main issues highlighted as part of this work, which require further consideration by the IAP include:

- The lack of compatible IT systems across the CJS
- Problems with the transfer of paper records
- Gaps in relation to training on the principles of information sharing and the lack of a centralised steer on this
- Local variation in practice in relation to information sharing and a lack of standardised documentation nationally
- Different cultural viewpoints on information sharing across the custodial sectors
- The problems of forging and sustaining effective local inter-agency and multi-agency partnerships

## **The Risks Relating to the Transfer and Escorting of Detainees Working Group**

An initial search undertaken by the OHRN has shown that there is not a large amount of information available in relation to this topic. They have been commissioned to carry out the following work, which is due for completion at the end of February 2010:

- Conduct a review of the literature around this subject and access reports and inquiries into any such deaths over the last ten years
- Produce a thematic overview of the findings and recommendations of these reports
- Liaise with agencies responsible for providing such escorts to produce an overview of current policies relating to escorting detainees to identify points of common or good practice and to identify any lessons, which could be shared across the custodial sectors

To inform this work, a focus group involving multi-disciplinary professionals from a number of relevant stakeholders will be held to clarify what issues and problems are

common or unique across the different custodial sectors with regard to the safe escorting of detainees. A meeting has taken place with representatives from the Prisoner Escort Management Unit (PEM) within NOMS to discuss the priorities for this group from their perspective and further meetings will take place with representatives from the police and National Health Service (NHS).