

# INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

END OF TERM REPORT  
FEBRUARY 2012



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## Foreword from Chair of IAP



This report marks the end of the Independent Advisory Panel (IAP) on Deaths in Custody's first term, following its creation in April 2009. It highlights the key achievements we have made, since our mid term report was published in March 2011<sup>1</sup>.

The Ministerial Council on Deaths in Custody, of which the IAP forms one tier, has been subject to an evaluation to determine whether the current arrangements should continue after March 2012. I am pleased to report that Ministers have approved continuation of the Council for a further three years, and to reappoint the individual Panel members for terms of either two and three years.

There has been strong Ministerial engagement with our work and their presence at Ministerial Board meetings has been helpful to the Panel in driving forward our work programme.

The Panel is committed to continuing its focus on developing safer practices to prevent deaths in custody and to ensuring learning is shared across sectors.

This report sets out our main achievements in detail and I would like to draw your attention to some key pieces of work.

In September 2011 the Panel, in conjunction with INQUEST, held its second family listening day. This event was specifically for families affected by the death of a relative detained under the Mental Health Act. We heard moving accounts from families which led to recommendations to the Ministerial Board, which will be used with develop a series of common principles for family liaison across all the custodial providers and investigation bodies. On behalf of the Panel, I would like to thank those families who shared their experiences with us.

In October 2011, Caring Solutions (UK) Ltd published a review of the medical theories and research behind restraint deaths, which was commissioned by the Panel. This review will allow custodial sectors to identify whether their restraint training packages

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<sup>1</sup>Available to download here: <http://iapdeathsincustody.independent.gov.uk/news/iap-publish-their-mid-term-report/>

effectively address the many medical dangers of applying restraint.

The Panel also published its first statistical analysis of all recorded deaths in custody. This publication was an important achievement for the IAP as this was the first time that all recorded deaths in state custody, including data on the deaths of patients detained under the Mental Health Act, was presented in one place.

The Panel welcomes the overall reduction of self-inflicted deaths since 2000. We are concerned to ensure that this reduction is maintained and would like to re-iterate the importance to custody providers of maintaining focus on this area, particularly at a time of stretched resources and continuous changes in governance.

Learning from deaths in custody forms a key part of the Panel's work and with this in mind, we commissioned Mendas in October 2011, to undertake research analysing the impact of coroners' Rule 43 letters on how the custody sectors learn from deaths in custody. This work is at an early stage, but I believe it will generate valuable insights into how the sectors could strengthen their processes and cultural approaches to facilitate learning from deaths.

The Panel have encountered frustrations along the way. A number of recommendations we made

in relation to Article 2 compliant investigations and deaths of patients detained under the MHA, whilst accepted in principle by the Ministerial Board, have not been progressed as far as the Panel would have liked. Uncertainties over the future governance and commissioning for health and ongoing modernisation of the Care Quality Commission's Mental Health Act monitoring function make it difficult to implement suggestions for change to policy and guidance. However, both CQC and Department of Health have continued to engage positively with the Panel to take forward changes as they become possible.

The Panel values engagement with its stakeholders. This has been vital to ensure we gain the right level of expertise to inform our work. In March 2011, we brought together members of our practitioner and stakeholder group for our inaugural stakeholder consultation event. This provided an excellent opportunity for the Panel to discuss potential recommendations with stakeholders and to ensure they were operationally viable. It also provided a valuable forum to hear from a bereaved family member and to sharing learning and best practice between organisations. Attendees were positive about the event and we will look to build on this success during our second consultation event in March 2012.

We have hosted a number of important roundtable discussions. For example, we examined the resource problems for provision of Section 136 of the Mental Health Act places of safety and approaches to improving the flow of information between criminal justice agencies. These meetings have enabled custodial sectors and regulatory bodies to work together to resolve longstanding operational problems.

I would like to express my thanks to the other Panel members for their commitment to our work as well as my gratitude to our small Secretariat for the enormous contribution that they have made over the last three years. I am also grateful for the collaboration we have had with staff in our co-sponsoring departments, who all share our commitment to reducing the number of avoidable deaths in custody.

The Panel is now focused on developing its work programme for the next term and we will be holding a consultation event on 2 March to hear from stakeholders about their view on priorities. If you would like to contribute to that event or have any comments about this report, please contact the IAP via the contact page on our website. The Panel would also like to attract more family members to our practitioner and stakeholder group.

A handwritten signature in black ink that reads "Toby Harris". The signature is written in a cursive, slightly slanted style. There is a small dot above the 'i' in "Harris" and a flourish under the 'y'.

Chair of the Independent Advisory  
Panel on Deaths in Custody

## Key IAP achievements

The IAP's mid term report, which was published in March 2011, summarised the IAP's initial achievements. This included the organisation of the IAP's first family listening day for families affected by the death of a relative whilst in prison and police custody; hosting of a cross sector restraint workshop to discuss common issues around the use of physical restraint and acquiring data from Coroners to understand the reasons and extent of delays in outstanding inquests into deaths in custody. Further details about this work can be found in the mid term report.

This section covers details of the Panel's main achievements since March 2011 and recommendations made to the Ministerial Board, which have been accepted and are now being progressed by the Panel<sup>2</sup>.

### 1. Statistical analysis of deaths in custody<sup>3</sup>

**1.1.** In October 2011, the Panel published its first statistical analysis of all deaths in state custody between 1 January 2000 and 31 December 2010. Where available, these deaths were broken down by ethnicity, gender, age and cause of death to allow readers to gain a fuller understanding of any themes in the data. Table 1 overleaf provides an overview of these figures:

**Table 1:** Summary of recorded deaths in state custody between 1 January 2000 and 31 December 2010<sup>4</sup>

- In total, there were 5,998 deaths recorded for the 11 years from 2000 to 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 the end of the reporting period).
- Deaths of those detained under the Mental Health Act (MHA) and those in prison custody, account for 92% (N=5,511) of all deaths in state custody, at 61% (N=3,628) and 31% (N=1,883) respectively.

**1.2.** The analysis highlighted that the overall numbers of deaths in custody has been reducing since 2000. The Panel particularly welcomes the reduction in self-inflicted deaths and believes this is a credit to custodial sectors efforts in addressing some of the underlying issues around these deaths but there is a need to focus on maintaining good practice at a time of stretched resources. Natural cause deaths are the largest proportion of all deaths in state custody, accounting for 66% (N=3,974).

<sup>2</sup> <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/02/IAP-recommendations-list.pdf>

<sup>3</sup> Available to download here: <http://iapdeathsincustody.independent.gov.uk/news/iap-publish-statistical-analysis-of-all-recorded-deaths-2000-2010/>

<sup>4</sup> Some percentages may add up to more or less than 100% due to rounding.

**Table 1:** Summary of recorded deaths in state custody between 1 January 2000 and 31 December 2010

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Prison <sup>1</sup>	146	142	164	182	207	174	153	185	165	169	196	1883
Police <sup>2</sup>	30	29	32	34	39	28	26	23	18	16	19	294
In-Patient Mental Health Setting (detained patients)	406	346	307	331	310	337	363	325	326	294	283	3628
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	179
STC / SCH <sup>3</sup>	0	0	0	0	2	0	0	0	0	0	0	2
Immigration detention <sup>4</sup>	1	0	0	2	4	2	1	0	0	0	2	12
<b>Total Deaths in State Custody for England and Wales</b>	<b>607</b>	<b>539</b>	<b>524</b>	<b>561</b>	<b>582</b>	<b>558</b>	<b>553</b>	<b>550</b>	<b>524</b>	<b>488</b>	<b>512</b>	<b>5998</b>

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 Haslar 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 (SCHs)

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

**1.3.** The Panel believe that this publication is a valuable resource for custodial sectors to learn from relevant trends in other sectors. It is also of use to our wider stakeholders and has featured in a number of publications including the Prison Reform Trusts' 'Bromley Briefing'<sup>5</sup>, and an issue of Black Mental Health's 'The Solution' magazine<sup>6</sup>.

**1.4.** The Panel will conduct an annual statistical analysis across the sectors and will develop our understanding as to whether there are equality issues such as potential dis-proportionality for women and Black and Minority Ethnic (BME) detainees.

## **2. Review of the medical theories on restraint deaths**

**2.1.** The government has a duty of care towards an individual in state custody - the right to life - which is enshrined in Article 2 of the European Convention on Human Rights (ECHR). Deaths following use of restraint by staff in custodial settings can be the most complex to examine, given the wide spectrum of medical and psycho-social reasons for such deaths. There has been significant debate in the medical community as well as in public and parliament. The Panel commissioned Caring Solutions (UK) Ltd and the University of Central Lancashire to undertake a review of the medical theories and research relating to restraint deaths in order to understand the physiological causes<sup>7</sup>.

**2.2.** The report was published in October 2011 and represents a serious

body of knowledge on why people die following the use of restraint . It evidences that certain groups are more vulnerable to risks associated with restraint<sup>8</sup> – either intrinsically, or 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).

**2.3.** A number of medical diagnoses and explanations are discussed in the report such as positional asphyxia, excited delirium, acute behavioural disturbance and alcohol abuse, which has helped the Panel to develop insights into the risks associated with restraint for certain groups<sup>9</sup>.

**2.4.** The review findings are now being developed to contribute to the Panel's work on reporting mechanisms on restraint as well as mental health awareness and restraint reduction techniques.

**2.5.** The Panel, in conjunction with the Association of Chief Police Officers (ACPO), have begun to identify ways of improving police reporting mechanisms on the use of restraint. ACPO provided a sample of use of force data from one police force, which we will be analysing to estimate the prevalence of use of restraint (i.e. how many times restraint was used in a given period and compared to the number of detainees), with a view to informing a justification for requiring police forces to submit annual use of force data for analysis by a suitable police body.

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<sup>5</sup><http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/12/Bromley-Briefing-December-2011.pdf>

<sup>6</sup><http://content.yudu.com/Library/A1ufcu/TheSolutionMagazine/resources/index.htm?referrerUrl=>

<sup>7</sup>To feed into this review an expert seminar was held involving key legal and medical experts, to peer review the initial findings.

<sup>8</sup><http://iapdeathsincustody.independent.gov.uk/news/review-of-medical-theories-on-restraint-deaths-published/>

<sup>9</sup>Ibid: 37

The Panel believes it is crucial to evidence how many times use of force occurs in order to gain an understanding of the situations that lead to restraint, to identify any safety issues, and to highlight good practice to share across the sectors.

**2.6.** This review, along with other strands of work undertaken by the Panel on restraint will inform the development of a series of common principles. Further details of these are included later in the report.

### **3. Learning from deaths in custody and inquest delays**



**3.1.** The Panel recognises that delays to inquests have an enormous impact on the family and staff involved. It also frustrates the opportunity to learn lessons from deaths in custody. We heard directly from bereaved families about the difficulties caused by unexplained delays to inquests, which places great emotional stress on them.

**3.2.** The Panel are pleased that the government decided to implement the

role of Chief Coroner, after a lengthy period of lobbying from interest groups about proposals in the Public Bodies Bill. We made two recommendations relevant to the office of the Chief Coroner and held a productive meeting in January 2012 to agree how these can be implemented<sup>11</sup>.

**3.3.** The Panel undertook research in conjunction with the Coroners' Society on the extent and reasons for delays in death in custody inquests<sup>12</sup>. Our paper was presented to the Ministerial Board in October 2011 and contained a series of recommendations aimed at reducing the delays and to ensure effective monitoring of standards. The Ministry of Justice (MoJ) have responded positively to most of the recommendations – including the need for coroners to be trained in case management to prevent avoidable delays. However, the MoJ will not be publishing statistics on death in custody inquests until 2013 so it will be difficult to assess the impact of these actions on timeliness of inquests. We hope the Chief Coroner will be instrumental in improving case management and timeliness of inquests. This is an ongoing area of concern for the Panel and we will monitor these developments.

**3.4.** The Panel has examined the governance arrangements in each of the custodial sectors for investigation and learning from deaths in custody. This revealed variation in the extent to which there are effective mechanisms for ensuring learning and good practice is implemented by specific providers

<sup>10</sup>These are the Panel's thematic review of Rule 43 Reports, narrative verdicts and investigation reports where restraint was identified as a direct cause or contributory factor in the death: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/12/Review-of-Rule-43-and-Narrative-Reports-on-Restraint-Deaths.pdf> and the Panel's report of the cross sector restraint workshop, held in May 2010: <http://iapdeathsincustody.independent.gov.uk/news/iap-publish-report-of-the-cross-sector-restraint-workshop/>

<sup>11</sup>These recommendations were made to the Ministerial Board in March 2010. They were: (1) that a specific reference to learning from deaths in custody is included within the remit of the new Chief Coroner and (2) that the new Chief Coroner is invited to sit on the Ministerial Board on Deaths in Custody.

<sup>12</sup><http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/11/Delays-in-DiC-Inquests-IAP-Cross-Sector-Learning.pdf>

and across the custodial sectors. The Panel has used these insights to inform research commissioned by Mendas on the impact of Coroner Rule 43 letters on custodial sectors' learning. The research commenced in December 2011, and the researchers are currently tracking a sample of cases across all sectors. Early findings show a huge variation in how sectors approach learning from Rule 43 letters in terms of structures and cultural attitudes to changing practices. The research will inform recommendations to the Ministerial Board in June 2012.

#### **4. Family liaison**

**4.1.** Family liaison is a key area for the Panel. We have been looking at how to improve provision of sensitive and timely family liaison services following deaths 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 police custody or following police contact. INQUEST facilitated the event, having been the successful bidder in an open competition. The report of the day was published on our website<sup>13</sup>, and the Panel have discussed the suggestions for improvement with the custodial sectors and investigative bodies.

**4.2.** To build on this work, we held a second family listening day with families affected by the death of a relative whilst detained under the Mental Health Act (MHA)<sup>14</sup>. Families reported common problems such as inadequate information about what to do; receiving news from staff who were not trained in family liaison; a

perceived lack of independence with investigations conducted by Trusts and the impact of delays to inquests. For those families whose relatives had been detained patients, there were particular problems about not being properly involved in investigations following the death and not receiving information from Trusts on completion of investigations. These findings will feed into the wider work being undertaken by the Panel on family liaison and Article 2 compliant investigations.

**4.3.** The Panel recommended to the Ministerial Board in February 2012 that Trusts should have procedures in place for ensuring good quality family liaison with bereaved families, including providing ongoing information and signposting families to other sources of support and advice. The Panel also recommended that Trusts should also keep families informed about investigations and any actions taken as a result of the death. The Department of Health accepted the recommendations and have agreed to discuss how they can be taken forward.

#### **5. Information sharing through the criminal justice system**

**5.1.** The Panel's wider work on collating recommendations from coroners Rule 43 Reports and narrative verdicts revealed that, of the 180 reports and verdicts collated, concerns about the effectiveness of information exchange within and between providers were mentioned in approximately 70 cases. The Panel has focussed on improving the flow of information relating to detainees' risk of self-harm / suicide and their healthcare records.

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<sup>13</sup><http://iapdeathsincustody.independent.gov.uk/news/iap-publishes-its-report-on-the-family-listening-day/>

<sup>14</sup><http://iapdeathsincustody.independent.gov.uk/news/iap-publishes-the-report-on-its-second-family-listening-day/>

**5.2.** An information sharing statement has been developed to summarise clearly for custodial staff how and why the need to share information. Stakeholder responses to the IAP's consultation on information sharing in April 2010 revealed that despite the plethora of guidance available, misunderstandings about data protection and the concept of medical confidentiality unnecessarily inhibited staff from sharing relevant information to manage detainees' risks of self harm and/or suicide.

**5.3.** This statement was endorsed by the Information Commissioner who believed it would go some way to ensuring that the Data Protection Act was not seen as a barrier to sharing information. The General Medical Council also support the purpose of the statement and will meet with the Panel in March 2012 to discuss how best to maximise its impact. The Panel will then work with the custodial sectors to identify how to communicate it and embed it in practice.

**5.4.** The Panel acknowledges that the updated Person Escort Record (PER)<sup>15</sup> is a marked improvement on previous iterations. Following discussions with stakeholders and after visiting a Young Offenders Institute (YOI) in October 2010, the Panel were concerned that in many cases there was insufficient detail (or out of date information) about the risk of harm and/or suicide to enable the recipient of the PER to effectively manage the risks presented by the detainee. As a result, NOMS issued a message to all governors in July 2011,

asking them to incorporate this insight into local PER training procedures.

**5.5.** On behalf of the Panel, Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Constabulary (HMIC) analysed a sample of PER forms completed by police. They inspected 181 PER forms from five forces to examine the extent to which information about the risk of self-harm obtained during detention in police custody was accurately recorded and likely to be useful in subsequent care planning as the detainee moved along the criminal justice system. This is a small sample, as 1 million PERs are completed each year.

**5.6.** Nevertheless, they found that forms were not fully completed in 33 of the 181 cases. Concerns were also highlighted about inconsistent or vague information and a lack of concordance between risk information on the PER and that on police custody records.

**5.7.** The Inspectorates encountered problems with following up how records were dealt with in prisons (in part due to limited access to the Prison National Offender Management Information System (P-Nomis)<sup>16</sup>). The IAP will discuss with HMIP / HMIC whether further work can be completed to track the flow of information from police to prison custody. The final report will be available for the Ministerial Board in June 2012.

**5.8.** In parallel, the Independent Custody Visitors Association (ICVA)<sup>17</sup> will incorporate audits of PER forms

<sup>15</sup>The PER was introduced in 1999. Information on the form is used to inform escort staff transferring the detainee and receiving agencies about any risk a detainee may present including risk to self, others and risk of escape. It is also used to highlight physical and mental health concerns.

<sup>16</sup>P-NOMIS was developed as a replacement for the Local Inmate Database System to support 'end to end' offender management within all public sector prisons. The system provides a single prisoner record stored on a single central data base.

<sup>17</sup>ICVA promotes and supports the effective provision of custody visiting nationally, raising public awareness on the rights and entitlements, health and wellbeing of people held in police custody and the conditions and facilities in which they are kept.

and report back any concerns to the police custody suite to enable quick time learning. The Lay Observers<sup>18</sup> already audit PER forms and the IAP will meet with both organisations in 2012 to discuss these results. The Independent Monitoring Boards (IMB) were also approached. But they they thought this requirement was beyond their remit<sup>19</sup>.

## **6. Article 2 compliant investigations**

**6.1.** The Panel has a special interest in the positive duties imposed by Article 2 of the European Convention on Human Rights (ECHR) for the state to protect life and the obligation to refrain from the unlawful taking of life. Deprivation of liberty creates particular vulnerabilities for detainees in terms of Article 2, and accordingly the obligations on the state are increased in such circumstances.

**6.2.** Professor Philip Leach made a number of recommendations to the Ministerial Board in June 2011, which are currently being taken forward<sup>20</sup>. These focused on (1) deaths of those detained under the MHA; (2) deaths in prison; (3) children who die in (or in transfer to or from) secure children's homes (SCHs); and (4) inquests.

**6.3.** The Panel agrees that inquests are the primary means by which the state discharges its duties to investigate deaths in custody. But we want to emphasise that the nature and extent of the investigations carried out before the inquest may also be critically important to ensuring Article 2 compliance.

**6.4.** In relation to deaths of detained

patients, the Panel raised concerns that the Department of Health (DH) guidance on commissioning independent investigations on deaths of detained patients applies only to cases of homicide (by any mental health service user) and to clusters of suicides. This compares unfavourably to the arrangements in place for other sectors on the key elements of Article 2 compliant investigations. The Panel made three recommendations to the Board, which were accepted in principle pending implementation of new NHS structures. We continue to meet DH regularly to ensure the Panel is fully informed of developments in this important area.

**6.5.** The Panel recommended improvements to the delivery of independent clinical reviews which form an important part of the Prisons and Probation Ombudsman's (PPO) investigation of deaths in prisons. The PPO have reported on the timeliness of reviews to the Panel on a regular basis and delays continue to be a problem, which in turn lead to delays to the inquest taking place. We are aware that the PPO is working with Offender Health to pilot improvements in the North West and we will continue to monitor whether or not these developments reduce delays.

**6.6.** The Panel recommended that the PPO's remit should be extended to investigate deaths of children in SCHs, and met a number of meetings with the Youth Justice Board (YJB), MoJ and Department for Education (DfE) to discuss how this could be taken forward. DfE did not agree that a PPO investigation would be required to

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<sup>18</sup>Lay Observers are responsible for observing the escort process between police stations, courts and prisons.

<sup>19</sup>The IMB are independent and their role is to monitor the day-to-day life in their local prison or immigration removal centre and ensure that proper standards of care are maintained.

<sup>20</sup><http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/01/IAP-Workstream-Paper-on-Article-2-Compliant-Investigations.pdf>

ensure Article 2 compliance – to which the Panel will respond in due course. However, DfE responded positively by saying that they would work with YJB and local authorities on the practical implications of extending the PPO's remit to cover investigations in SCHs to ensure consistency for the secure youth estate. The Panel welcomes their willingness to take forward this important piece of work.

## **7. National specification for police escort vans**

**7.1.** In June 2011, the Panel identified a series of risks relating to the transfer of detainee process, which included: (i) Transfer of Young People to SCHs; (ii) Appearance of Young and Vulnerable People at Court; (iii) UK Border Agency Deportation Flights; (iv) Transfer of Individuals Suffering from Drug Intoxication and; (v) National Specification for Police Escort Vans.

**7.2.** ACPO informed the IAP in December 2010, about the development of a national specification for the design of police escort vehicles (as there had previously been no national guidance). The specification was prompted following a report by North Yorkshire Police into a near miss incident of positional asphyxia during transportation. The aim of the specification is to create a consistent design for police vans to ensure they meet minimum safety standards.

**7.3.** The IAP were invited to formally comment on the draft specification and in May 2011, Dr Peter Dean recommended the following:

- The Panel have longstanding concerns over the dangers of

positional asphyxia during a police arrest situation. On 7 September 2003, Michael Powell died whilst being transported in the back of a police van. At the inquest into his death, it was found that Mr Powell died of positional asphyxia, in a police van prior to his removal from it. The IAP believed this was an opportune time to recommend the inclusion of clear signage in the back of police vans, reminding police officers to check for the warning signs of positional asphyxia, acute behavioural disorder and head injuries.

- To ensure that the draft specification takes into consideration the needs of rural police forces, given the different challenges faced by rural forces over urban forces. These include greater transportation times between population centres and fewer police officers policing a more dispersed population.

## **8. Section 136 of the MHA<sup>21</sup>**

**8.1.** One of the Panel's main concerns about the transfer and escorting of detainees is the conveyance of detainees subject to Section 136 of the MHA. Previous research conducted by the Independent Police Complaints Commission (IPCC) highlighted that police officers were often unable to take Section 136 detainees to a place of safety other than a police station, either because it simply did not exist or because hospital staff refused to accept detainees who were intoxicated or violent<sup>22</sup>. The Panel believe that police custody is not the best place for Section 136 detainees given the vulnerabilities of the detainee and the

<sup>21</sup>Under Section 136 of the Mental Health Act, the police can remove from a public place to a place of safety a person who appears to have a mental disorder and to need immediate help.

<sup>22</sup>Hannan M., Grace K., Bucke T. (2008) Police Custody as a 'Place of Safety': Examining the Use of Section 136 of the Mental Health Act 1983: 19

lack of ready access to mental health professionals.

**8.2.** In November 2011, the Panel chaired a roundtable bringing together ACPO, the Care Quality Commission (CQC), HMIC, IPCC, Metropolitan Police Service, Offender Health and the Royal College of Psychiatrists. The aim of this was to identify what local arrangements were in place for the provision of Section 136 detainees and to discuss potential costs of staffing additional places of safety (in the context of ongoing budget cuts). There was a consensus from attendees that police custody was not the best place to detain a person under Section 136. Both CQC and IPCC thought accuracy of the data on Section 136 detentions could be improved, especially to capture the outcome following initial contact with the police. ACPO and IPCC had agreed to discuss how this could be included in the annual custody data returns. The Panel will monitor the outcome of these actions.

**8.3.** However, there was a lack of evidence about how extra resources had been used by trusts to create places of safety in health settings, and there were anecdotal accounts that new provision was under-used due to pressure on staff resources.

**8.4.** The Panel have worked with ACPO and DH to identify how the extra resources have been disbursed and to ascertain the level of compliance with the DH / ACPO memorandum of understanding for the provision, management and conveyance to places of safety of those individuals

detained under Section 136. ACPO and DH presented a joint paper to the Ministerial Board in February 2012, which included feedback from 36 police forces. This showed that the use of health based places of safety is increasing but there is a mixed picture – with some very effective police and health trust partnerships and low usage of police custody, compared to areas where police custody is used more frequently and partnerships are functioning less well. The report highlighted that some forces were also unable to secure adequate access to health based places of safety, primarily because of their unwillingness to accept intoxicated detainees.

**8.5.** The paper recommended that the future NHS Commissioning Board (NHSCB) (subject to the passage of the Health and Social Care Bill) should commission health based places of safety alongside offender health services. The IAP welcomes this recommendation and recognises the importance of clear commissioning responsibility for Section 136 places of safety. The Panel will continue to monitor the commissioning and use of health based places of safety to ensure that practice improves and the use of police stations is minimised.

**8.6.** The Panel also heard from CQC about their inspection on Section 136 places of safety across London. This is welcomed by the Panel and we will be working with CQC to encourage Trusts and police to apply any learning points from the inspection.

## **9. Deaths of patients detained under the MHA**

**9.1** The Panel commissioned Offender Health to undertake an analysis of CQC data on natural cause deaths of detained patients in England. The analysis was presented to the Ministerial Board in March 2011 with recommendations aimed at improving physical healthcare for detained patients<sup>23</sup>. The analysis showed that between 2003-2009 1,671 natural cause deaths occurred, of which 23% were due to pneumonia; 20% due to myocardial infarction; 8% due to pulmonary embolism and 6% due to medical or surgical emergencies.

**9.2** The Panel made a number of recommendations to the Board. One of which was to ensure that the importance of improving the physical health of detained patients was included in the mandate for the NHS Commissioning Board (NHSCB). The Panel met Department of Health in December to take stock of progress on the recommendations, and we are pleased they are willing to engage the NHS Information Centre to look into aligning data sources on detained patients. Nevertheless, the Panel has been concerned about the difficulties in implementing change in this area until the operation of the National Patient Safety Agency's functions are transferred and the governance structure for the NHSCB is in place.

**9.3** The Panel also recommended changes to the data collected by CQC when Trusts notify them of deaths of detained patients to ensure

information is available on physical health problems. CQC agreed to this in principle but it is disappointing that they have not yet been able to amend the IT system required to record the information. This is now planned for March 2012. In September 2011 the Chair met Dame Jo Williams, Chair of CQC, to discuss their role following the death of detained patients. This was a positive meeting, although it was clear that CQC were still in the process of developing their response to deaths of detained patients as part of their wider programme for modernising their mental health function. CQC recently updated the Panel, explaining that they aimed to confirm their position in relation to deaths in custody in February 2012 and have agreed to update the Panel shortly after.

**9.4** The Panel has also engaged with Third Sector organisations representing the views of mental health service users to develop its work on deaths of detained patients and we are keen to develop these relationships in our second term.

## **10. Stakeholder consultation event**



<sup>23</sup><http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/02/IAP-recommendations-list.pdf>

**10.1.** In March 2011, the Panel held its first national stakeholder consultation event, which was attended by over 120 delegates<sup>24</sup>. The event was designed to consult and engage stakeholders and to give them an opportunity to shape the Panel's work programme and test that our recommendations could be applied in operational settings.

**10.2.** The Panel were keen to ensure that attendees heard about a family's perspective on a death in custody and the subsequent investigation and inquest. A family member, whose brother died at HMP Brixton in 2006, spoke at the event and feedback from attendees highlighted how important it was to hear these experiences, and how it reminded them of the importance of learning from deaths in custody. Indeed, as a result the Chief Executive of NOMS took action to amend family liaison practices. He wrote to prison governors reminding them of the importance of offering personal condolences to families affected by the death of a relative. He also instructed governors to keep families informed following receipt of investigation and inquests into the death, to ensure they were aware of any action being taken to address recommendations for improvement. The Panel welcomes these developments in ensuring that effective family liaison mechanisms are in place and we will follow up to monitor whether changes have been embedded.

**10.3.** Stakeholders appreciated having a cross sector forum allowing them to hear experiences from other custody sectors, to share best practice and acquire relevant learning to disseminate within their own sectors. The IAP is looking to build on the successes of the first event in the delivery of our second event on 2 March 2012, which will mark the beginning of the IAP's second term.

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<sup>24</sup>For a summary of the event's main discussions and findings, please read the April 2011 IAP e-bulletin, available here: <http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/e-bulletins/>

## Future priorities for the IAP

### 11. New work

**11.1.** At the IAP's strategic planning meeting in January 2012, we identified a number of areas we would like to focus on going forward. These included development of existing projects, such as common principles on the use of restraint and monitoring implementation of the information sharing statement. Panel members have also proposed new projects, including the development of a statistical analysis to understand whether vulnerable groups are over-represented in the numbers of deaths in custody. The Panel will be consulting on the strategic plan for 2012/13 at the national consultation event on 2 March 2012, which is a key opportunity for testing out ideas and identifying priorities with stakeholders.

**11.2.** The following major pieces of work will be progressed:

### 12. Common principles on use of restraint

**12.1.** These principles will cover factors such as, but not limited to:

- 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 mental disorders or having consumed drugs/alcohol and;

- recovery procedures following the use of restraint including the involvement of healthcare staff.

**12.2.** The aim of these would be to bring about an improvement in operational practices across the custodial and health and care sectors where patients are detained in order to reduce the number of restraint related deaths in the future.

**12.3.** These will be developed in partnership with the custodial and health and care sectors and a meeting will be held in March 2012 involving officials from ACPO, NOMS, HM Prison Service National Tactical Response Group, UK Border Agency and NHS. We will seek comments on the draft principles, discuss any potential inclusions and address contentious issues. The Restraint Advisory Board will also attend in an advisory capacity. This meeting will also be used to explore the feasibility of the restraint reduction pilots, an area of work the Panel wish to take forward from the review of the medical theories.

**12.4.** The Panel will work with the custody and health and care sectors to establish how these principles are communicated and implemented in training packages and to devise a way of monitoring their impact on operational practices.

### **13. Embedding the information sharing statement**

**13.1.** The Panel will monitor whether this statement has been implemented. We have identified a number of potential monitoring mechanisms, including: IMB, ICVA, Lay Observers, HMIP, HMIC, HMI Probation, Ofsted, CQC, dialogue with custody sectors learning forums and the investigative bodies.

**13.2.** The Panel will also evaluate the impact of the statement to understand whether it has had an influence on improving information sharing practices and procedures. This may take the form of joint work with the Inspectorates and focus group meetings.

### **14. Family liaison – development of protocols**

**14.1.** In addition to monitoring implementation of the Panel's recommendations for improved family liaison by Mental Health Trusts, we will be working with the custodial sectors and investigatory bodies to develop and implement common principles on the delivery of high quality family liaison for those whose relatives die in custody.

### **15. Mental health and research into investigations of deaths of detained patients**

**15.1.** The Panel proposes to develop its understanding of the risks of self-inflicted death for mentally ill detainees in all custodial settings. We will also be examining the system for investigation of deaths of detained patients by researching how and why

strategic health authorities commission independent investigations in self-inflicted cases. This will enable the Panel to draw conclusions about the quality and timeliness of such investigations and provide an evidence base for developing recommendations for change in this sector.

## Members of the IAP



**Lord Toby Harris** is Chair of the IAP. He is a former Chair of the Metropolitan Police Authority and the Association of London Government. In Parliament, he sits on the Joint Committee on National Security and Chairs the All-Party Parliamentary Group on Policing.



**Simon Armson** is currently a clinical psychotherapist, a Mental Health Act Commissioner and a Member of the Mental Health Review Tribunal. He is also a Mental Health Act Manager at a large London Mental Health NHS Trust. He chaired the Mental Health Act Commission for a period in 2008/09. From 1989 to 2004, he was Chief Executive of the Samaritans, having worked as a Samaritan volunteer for 31 years, and was instrumental in developing that organisation's work in prisons. He has a particular interest in mental health and suicide prevention. Simon leads the IAP workstream on the deaths of patients detained under the Mental Health Act and contributes mental health expertise to other Panel members workstreams.



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



**Dr Peter Dean** is an experienced coroner in Suffolk and Essex and a Forensic Medical Examiner with the MPS, with a background in general practice. He has knowledge and experience of deaths in police and prison custody and has provided advice, guidance and training to police custody staff for some years. Dr Dean leads the IAP workstream on the risks relating to the transfer and escorting of detainees.



**Professor Philip Leach** is a Professor of Human Rights at London Metropolitan University and a former Legal Director of Liberty having originally trained as a solicitor. He has undertaken training in human rights for prosecutors, police and judges and been involved in casework with prisoners, and raising various aspects of Article 2 of the European Convention on Human Rights, both in the UK and internationally. Professor Leach leads the IAP workstream on Article 2 compliant investigations.



**Professor Richard Shepherd** is a registered Home Office Forensic Pathologist and a leading forensic pathologist in the field of deaths during restraint, with experience of deaths in all forms of custody, including natural, suicidal and homicidal causes. Professor Shepherd leads the IAP workstream on the use of physical restraint.



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

# INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

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