Ministry of JUSTICE

Home Office

DH Department of Health

IAP recommendations made to the Ministerial Board on Deaths in Custody

Since 1 April 2009, there have been eight meetings of the Ministerial Board on Deaths in Custody[1]. The table below lists the recommendations made by the IAP to the Ministerial Board, along with the status of the recommendations and the progress of taking these forward.

Last updated: 21 February 2012

Ministerial Board on Deaths in Custody – 4 March 2010			
Workstream & Panel member	**Recommendation**	**Recommendation Status**	**Details & Update**
Use of Physical Restraint Professor Richard Shepherd	**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.	**Accepted - Complete**	• Analysis presented to the Ministerial Board in June 2011.
Use of Physical	**2.** The IAP to hold a cross sector	**Accepted -**	• Cross sector workshop was held in May 2010 and

[1] There were two Ministerial Boards, held on the 18 June and 15 October 2009, however, the IAP did not make recommendations at these meetings.

Restraint	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.	**Complete**	the report was presented to the Ministerial Board in October 2010. • The report contained five recommendations. See recommendation 10-14.
Use of Physical Restraint	**3.** The 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.	**Accepted - Complete**	• Caring Solutions (UK) Ltd was commissioned in February 2011 to carry out the analysis of medical theories and research relating to restraint related deaths. • Expert seminar was held on 10 June 2011 to feed into the review and the final report was presented to the Ministerial Board in October 2011 and published on the IAP website.
Cross Sector Learning Deborah Coles	**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.	**Accepted - underway**	• Secretariat has commissioned research from Mendas to look at the impact of Rule 43 reports on sectors' learning from deaths in custody. For presentation to the Ministerial Board in June 2012.
Cross Sector Learning	**5.** That a specific reference to learning from deaths in state custody is included within the remit of the new Chief Coroner.	**Accepted - underway**	• Following the government's decision not to abolish the role of Chief Coroner, the IAP met policy leads in MoJ on 16 January to discuss their recommendations on coronial reform. MoJ were planning to hold workshop in early February to consider the role and resource available to the Chief Coroner. This would include duties in relation to

			Rule 43 letters and responses. Lord Harris explained that the Panel hoped there would be a more in depth analysis of the quality of such reports and the themes in any learning arising. • MoJ agreed to consider how deaths in custody could be incorporated into the Chief Coroner job description.
Cross Sector Learning	**6.** That the new Chief Coroner is invited to sit on the Ministerial Board on Deaths in Custody.	**Accepted - underway**	• Following the government's decision not to abolish the role of Chief Coroner, the IAP met policy leads in MoJ on 16 January to discuss their recommendations on coronial reform. Policy leads agreed the invitation would be extended to the Chief Coroner, once appointed.
Cross Sector Learning	**7.** That guidance is developed specifically for Coroners to assist them with the production of Rule 43 Reports.	**Accepted – complete**	• The IAP will feed into the development of the *Guidance for Coroners on Changes to Rule 43: Coroner Reports to Prevent Future Deaths*. • This guidance is due to be re-drafted in September 2011 and will be discussed at the Ministerial Board in October 2011.
Cross Sector Learning	**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.	**Accepted - complete**	• The IAP, in conjunction with the Coroners Society, issued a coroners' questionnaire in August 2010 to obtain accurate data on the numbers of outstanding inquest into deaths in custody and the reasons for any particular delays. • The IAP produced a paper for the Ministerial Board in October 2011 setting out delays and reasons given, with a series of recommendations (see 32-39).

Ministerial Board on Deaths in Custody – 17 June 2010			
Workstream & Panel Member	**Recommendation**	**Recommendation Status**	**Details**
Cross sector learning – Family Liaison Deborah Coles	**9.** The IAP recommends that further work is undertaken with the Co-sponsors of the Ministerial Council to agree a standardised cross sector approach for the following: • The procedure for informing families about the death of a relative whilst in state custody. • The key information sources for families following bereavement. • A post-inquest protocol to ensure that families are kept informed of the subsequent actions and changes to policies and procedures as a result of the death, the investigation and inquest.	**Accepted – ongoing**	• In September 2010, a meeting was held with representatives from the UK Border Agency (UKBA), National Offender Management Service (NOMS), IPCC, PPO, CQC, the Coroners Society, INQUEST and the Department of Health. • Attendees agreed that there would be value in developing a set of common cross sector covering the process for notifying families following a death in custody, the key information sources shared with families and the importance of having procedures in place to ensure that families are informed of any changes to policy/practice as a result of the death. • There was also broad agreement that it would be helpful for the IAP to develop a specific leaflet around deaths in custody, which informed families about the post mortem and inquest process and signposted them to further guidance to ensure that all families received consistent information in the first instance. • In March 2011, following the IAP national stakeholder consultation event, the Chief Executive of NOMS wrote to Governors to ask them to write to families following receipt of the PPO's investigation report and at the conclusion of the inquest to inform them of action being taken to address any recommendations made by the PPO or the Coroner.

Ministerial Board on Deaths in Custody – 21 October 2010			
Workstream & Panel Member	**Recommendation**	**Recommendation Status**	**Details & Update**
Use of Physical Restraint Professor Richard Shepherd	**10.** The IAP recommends that local police forces submit use of force and restraint statistics on an annual basis to a suitable central body for monitoring and analysis purposes.	Recommendation from the report of the cross-sector restraint workshop held in May 2010. **Not Accepted**	• Home Office believe that whilst each force should have a system in place to monitor 'use of force', the introduction of central collation requirements would increase bureaucracy at a time when the Government is seeking to minimise it and have unfunded resource implications. • In January 2012, following the IAP's request to ACPO, the Panel received a sample of use of force data from a police force. The IAP will analyse this data to identify whether there are any issues and to estimate the scale of police use of restraint with a view to informing a national business case can be made requiring police forces to submit annual use of force data to a suitable police body for analysis.
Use of Physical Restraint	**11.** The IAP recommends that custodial sectors develop protocols to ensure that investigations are triggered in cases where the use of restraint has resulted in the near death or serious injury of an individual.	Recommendation from the report of the cross-sector restraint workshop held in May 2010. **Not Accepted**	• Protocols already in place to capture learning.

Use of Physical Restraint	**12.** The IAP recommends, in due course, that the Restraint Advisory Board (RAB) should ensure that the systems of restraint used in Local Authority Secure Children's Homes (LASCHs) are accredited.	• Recommendation from the report of the cross-sector restraint workshop held in May 2010. **Accepted**	• MoJ officials in conjunction with the Chair of the RAB are currently in discussions with the Department for Education about whether it would be possible for the RAB to assess systems of restraint used in Secure Children's Homes.
Use of Physical Restraint	**13.** The IAP recommends the creation of national guidance for UK Border Agency (UKBA) detention staff on how to safely restrain children under the age of 10.	• Recommendation from the report of the cross-sector restraint workshop held in May 2010. **Accepted - ongoing**	• UKBA have de-prioritised their work on creating national guidance for detention and escort staff on how to safely restrain children under the age of 10. In the first instance, with NOMS, they are concentrating on adapting techniques which are already accredited for immigration escorts to make them safer. • UKBA have committed to updating the IAP once work on creating the guidance has begun.
Use of Physical Restraint	**14.** The IAP recommends that further discussions are undertaken with RAB to establish the feasibility of them holding an extended meeting once a year to include representatives from all of the custodial sectors in order to share best practice and learning.	• Recommendation from the report of the cross-sector restraint workshop held in May 2010. **Accepted- complete**	• The Youth Justice Policy Unit in the Ministry of Justice held an event on 28 November, attended by a wide range of stakeholders including IAP.

Ministerial Board on Deaths in Custody – 16 March 2011			
Workstream & Panel Member	**Recommendation**	**Recommendation Status**	**Details & Update**
Deaths of Patients detained under the Mental Health Act Simon Armson	**15.** The IAP recommends that further analysis is undertaken by the Care Quality Commission with input from the National Patient Safety Agency (NPSA) or its successor body to examine the reasons for the high numbers of deaths from myocardial infarction (MI) and pulmonary embolism (PE) amongst those detained under the MHA.	**Accepted – CQC to confirm timescales.**	• The IAP met with CQC following the Board. They are updating the statutory notification form for deaths of patients detained under the Act. It will include more information about the death, including the primary and secondary diagnosis, and information on physical health needs. • This will help future examination of deaths of patients detained under the Act to analyse the circumstances of individual deaths in more detail, including any gaps in physical healthcare provision. • This will potentially provide more evidence to understand the reasons for high numbers of deaths in particular age groups, such as the large number of deaths attributed to pulmonary embolism in younger men. • The Panel received a letter from CQC in January 2012 confirming that they will be liaising with their Commissioners about their remit on deaths in custody.
Deaths of Patients detained under the	**16.** The IAP recommends that the requirement for inpatient mental	**Accepted - complete**	• There is already a legal requirement in England for all registered mental health care providers to take

Mental Health Act	health care providers to have up-to-date protocols in place for responding to medical and surgical emergencies is included in the NHS Operating Framework and consequently mandated in the NHS Standard Contract for Mental Health. If this is not feasible, the Department of Health should explore alternative options to ensure that this recommendation is met.		proper steps to ensure that service users are protected against the risks of receiving care or treatment that is inappropriate or safe. CQC compliance guidance specifically mentions the need for staff to be able to recognise quickly when someone becomes seriously ill, and to be able to respond immediately to their needs, if necessary, by arranging for their transfer to another service.
Deaths of Patients detained under the Mental Health Act	**17.** The IAP recommends that an appropriate central body undertakes further scoping work to identify all forms of data currently collated in relation to those detained in order to improve the alignment of these data collection systems and add robustness to any subsequent analysis.	**Accepted - ongoing**	• The Department of Health met with the NHS Information Centre for Mental Health and Social Care (IC). The IC holds the majority of the data set on detained patients and can provide stratified data. • However, the IC data does not include information from the high security hospitals and is only partially complete from private sector providers. • From 2011/12, the Mental Health Minimum Data Set (MHMDS) collection by the IC will be much more complete, including the Mental Health Act Legal Status Start Time and End Time to enable the order of transitions between different sections of the MHA to be calculated. This will give a more comprehensive data source and enable other comparisons to be made to the death data, such as length of time spent under specific sections.
Deaths of Patients detained under the Mental Health Act	**18.** The IAP recommends that the Department of Health ensures that a specific focus upon	**Accepted in principle. Depends on development of**	• The NHS Outcomes Framework was published in December 2010, which subject to the passage of the Health and Social Care Bill will drive the work

	improving the physical health of patients detained under the MHA is included within the mandate for the new NHS Commissioning Board.	**NHSCB.**	of the NHS Commissioning Board (NHSCB). It contains five domains, one of which is entitled 'preventing people from dying prematurely' with one of the supporting indicators being 'under 75 mortality rate in people with serious mental illness'. Another domain is 'treating and caring for people in a safe environment and protecting them from avoidable harm'. • The indicators developed for this domain will apply to all service provision, including mental health services. • The Department of Health guidance to providers and commissioners of low, medium and high secure services continues to emphasise the importance of the physical health needs of patients in secure services.
Deaths of Patients detained under the Mental Health Act	**19.** The IAP recommends that the Department of Health ensures that a greater focus is placed upon addressing the physical healthcare needs of those detained upon admission and discharge, as part of the delivery of the new mental health strategy.	**Accepted in principle - ongoing**	• The Department of Health have committed to work with the Royal College of Psychiatrists and GPs to develop guidance for commissioners of mental health services that includes a focus on physical care of mental health patients. Hugh Griffiths (National Clinical Director for Mental Health) raised the issue at the inter-professional collaborative meeting in September. The professions were keen to raise the profile of the issue and a further meeting is being planned to devise a programme of work. In addition, specific steps are being considered to prevent untreated diabetes (and associated potential deaths) in mental health patients.
Information Flow through the Criminal Justice System	**20.** The IAP recommends the development of clear and concise national cross-sector guidance (supported by	**Accepted – ongoing**	• An information sharing statement has been developed by the IAP reminding agencies of the need to share information on a detainee's risk of self harm / suicide and healthcare

Professor Stephen Shute	appropriate training) on the protocols of sharing information and healthcare records between custodial sectors.		records with other agencies. The Information Commissioner has endorsed the statement and the IAP is seeking a similar endorsement from the General Medical Council. • The IAP will engage with the custody sectors on how best to use their methods to communicate this to their practitioners and will monitor and evaluate its impact in 2012/13.
Information Flow through the Criminal Justice System	**21.** The IAP recommends that PSO 4630 is amended to make it mandatory for discharging prison establishments to send core records of time served prisoners with them when they are transferred to Immigration Removal Centres.	**Accepted - complete**	• This has been reflected in PSI 52/2011 which has replaced PSO 4630.
Information Flow through the Criminal Justice System	**22.** The IAP recommends that a formal analysis of a sample of Person Escort Record (PER) forms be undertaken by NOG and an appropriate central police agency to identify ways of improving the quality and consistency of information recorded on the PER.	**Accepted - ongoing**	• On behalf of the Panel, Her Majesty's Inspectorates (HMI) of Prisons and HMI Constabulary have inspected 181 PER forms from five forces to gather data about 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. • The IAP will discuss with HMIP / HMIC how they plan to publish the report and to agree 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 next Board in June 2012.

			• The Independent Custody Visitors Association (responsible for visiting police custody suites) and Lay Observers (responsible for observing the escorting process) have agreed to undertake audits of PER forms, reporting issues back to the custody suites / escort providers. The IAP will meet with both organisations in 2012 to discuss these results in greater detail. • The Independent Monitoring Board (IMB – responsible for monitoring the wellbeing of individuals in prison custody) thought this requirement went beyond their remit.
Ministerial Board on Deaths in Custody – 21 June 2011			
Panel Member	**Recommendation**	**Recommendation Status**	**Details & Update**
Article 2 Compliant Investigations Professor Philip Leach	**23.** The IAP recommends that research should be undertaken to review the quality of independent investigations carried out by Strategic Health Authorities.	• **Accepted in principle pending outcome of NHS reforms.**	IAP held a meeting with the National Clinical Director for Criminal Justice to discuss independent investigation – these mainly seem to be following homicides. The Panel is considering a research project and is discussing with Department of Health (DH) how to ascertain whether independent investigations are being commissioned by SHAs.

Article 2 Compliant Investigations	**24.** The IAP recommends that the National Patient Safety Agency (NPSA) good practice guidance on the 'Independent Investigation of Serious Patient Safety Incidents in Mental Health' should be re-written when the future governance of NPSA's functions have been decided to address the shortcomings addressed by the Panel and to ensue consistent application by all Trusts.	• **Accepted in principle pending outcome of NHS reforms.**	The Panel is working with DH to understand the timescales and remit of the NHS Commissioning Board, and to consider how these changes might present opportunities for enhancing guidance on independent investigation of deaths of detained patients.
Article 2 Compliant Investigations	**25.** The IAP recommends that those responsible in the new NHS Commissioning Board (NHSCB) should produce adequate guidance to clarify when independent investigations into deaths of detained patients.	• **Accepted in principle pending outcome of NHS reforms.**	The Panel is working with DH to understand the remit and timescales for implementation of the NHS Commissioning Board – and to take an early opportunity to raise the issue of guidance for when independent investigations should be completed.
Article 2 Compliant Investigations	**26.** The IAP recommends that the Care Quality Commission should devise a specific, discrete role in relation to reviewing deaths of detained patients and consider whether it can undertake and / or commission investigations. It should report back to the Ministerial Board on progress.	• **Accepted - underway**	The Chair of the IAP met the Chair of CQC in September to discuss how their role will be developed in relation to deaths of detained patients. CQC are working on how to integrate their mental health function and are looking at their role in relation to following up deaths of detained patients. CQC updated the Panel on progress in January 2012. They plan to discuss this with their commissioner to confirm their remit.
Article 2 Compliant	**27.** The IAP recommends that the	• **Accepted-**	Data has been submitted covering two quarters,

Investigations	Prisons and Probation Ombudsman (PPO) should follow up the analysis conducted in 2009 of clinical reviews, in conjunction with the IAP, to examine the effect of shared governance on quality; timeliness and independence of clinical reviews, six months after implementation, and regularly thereafter. They should share findings of these analyses with the IAP to review progress.	**underway**	showing a further downturn in timeliness of clinical reviews. The Panel has continued to seek information on action being taken to improve timeliness – there is a pilot in the NW SHA area on a range of activities to address quality and timeliness. The Panel will await the outcome of the pilot before pursuing further.
Article 2 Compliant Investigations	**28.** The IAP recommends that the PPO should be placed on a statutory footing to ensure independence from the Ministry of Justice.	• **Accepted in principle pending further consideration by the Ministry of Justice.**	The Panel has discussed this recommendation with the Ministry of Justice – who have confirmed that although there is no objection in principle to putting the PPO on a statutory footing, there is no suitable legislative time at present. The Panel will continue to raise the importance of this issue to confirm independence of the PPO.
Article 2 Compliant Investigations	**29.** The IAP recommends that all deaths in Secure Children's Homes should be investigated by the PPO.	• **Accepted in principle pending further consideration by the Ministry of Justice.**	The Panel met a range of organisations: YJB, PPO, SCH, MoJ and Ofsted to discuss this recommendation. All were supportive in principle – pending resolution of funding and legal advice, although DfE were unable to attend. The matter has been discussed by DfE and MoJ policy leads and lawyers who wrote to the Ministerial Board in time for their discussion on 7 February. DfE agreed to consider the practical and policy implications of having PPO investigate deaths in SCHs but did not agree this was required in order to comply with Article 2. DfE and MoJ will be invited to update the Ministerial Board in June 2012.
		• **Accepted in**	

Article 2 Compliant Investigations	**30.** The IAP recommends that the model for providing standard-setting guidance and oversight for Coroners should focus on deaths in custody to consider, monitor and ensure improvement in relation to the following: • Delays • Disclosure/access to documents • Family participation • Public funding for family legal representation • Resources for Coroners	**principle, pending appointment of Chief Coroner**	At an update meeting on 16 January with MoJ, Lord Harris questioned the extent to which the Charter would sufficiently address the problems with death in custody inquests. MoJ explained that in addition to the duty on coroners to report cases older than 12 months, the Chief Coroner would have case management powers to ensure cases are appropriately transferred or to appoint a retired coroner to sit on a case in order to reduce delays. Difficulties with delay could be addressed using new inquest rules which could be made under section 45 of the Coroners and Justice Act 2009, or regulations made under section 43. This will be pursued in due course. Guidance for families on inquests will be included in the information at the front of the Charter, which is due for publication in March 2012. See here for most recent version (which has not be significantly amended following public consultation: http://www.justice.gov.uk/downloads/consultations/draft-charter-coroner-service.pdf) Resources will continue to be an issue, although the MoJ have conducted a training course to help coroners with resource management and articulating their needs with local authorities. The Chief Coroner's relationship with local authorities (perhaps through Local Government Association) will have to be developed.
Risks Relating to the Transfer and Escorting of Detainees	**31.** The IAP recommends that the Care Quality Commission ensure that trusts are reminded of their obligations under the Mental Health Act in accepting	• **Accepted.**	• The Care Quality Commission are addressing this recommendation as part of their inspection programme of Section 136 places of safety and their wider work investigating the use of the Mental Health Act.

Dr Peter Dean	detainees subject to Section 136 of the Act.		• They also advised that once the future of the NHS Commissioning Board (NHSCB) was apparent, there may be a role for the NHSCB to commission and monitor healthcare places of safety.
Ministerial Board on Deaths in Custody – 18 October 2011			
Panel Member	**Recommendation**	**Recommendation Status**	**Details & Update**
Cross Sector Learning Deborah Coles	**32.** The IAP require more detailed information about delays in CPS decisions and their impact on death in custody inquests as well as delays to IPCC investigations. The Panel will continue to receive data from the PPO on the reasons for delay to investigations.	• **Accepted in principle pending further discussions.**	The Panel has discussed this with IPCC in an attempt to agree how information can be collected and analysed. IPCC do not record the length of delays caused by awaiting CPS decisions but they have been working with the CPS to minimise any delays by meeting quarterly to discuss cases. There are plans for CPS to handle all deaths in a single central team which will help build expertise in death cases. Delays may also be reduced now that the Director of Public Prosecutions has stopped reviewing all deaths.
Cross Sector Learning	**33.** The MoJ Coroners and Burials Unit should carry out an annual audit and identify districts where delays are greatest and discuss the reasons with the coroner to formulate an improvement plan in conjunction with the local authority, including the allocation of additional	• **Accepted in principle pending further discussions.**	MoJ believe this role will be fulfilled by Chief Coroner, given their powers to collect information and report on delays on death in custody cases. The Chair of the Panel raised this with MoJ at their meeting on 16 January to underline the importance of the Chief Coroner's office undertaking an analysis of the reasons for delays to identify and implement potential solutions.

	resources. This could include supporting coroners to make submissions to the relevant local authorities where funding is an issue.		
Cross Sector Learning	**34.** From 2012, Ministry of Justice (MoJ) statistics on inquests will report specifically on performance on death in custody cases and should require Coroners to report on delays of over one year, two years, for death in custody cases and the reasons for these. The figures should be reported to the new MoJ Ministerial Board (if the Chief Coroner role is not implemented) and the Lord Chancellor, and placed in the public domain through Parliament.	• **Accepted in principle pending further discussions.**	The Chief Coroner will report formally on delays to inquests, particularly on cases taking over one year to complete. The MoJ statistics specifically on death in custody inquests, which adds detail on performance in this area, will be available for use by mid 2013.
Cross Sector Learning	**35.** The relevant senior representatives of local authorities should be accountable to the proposed Ministerial Board structure to respond to concerns about lack of funding for particular districts and to ensure there is an understanding at local authority level of the impact of delays on bereaved families and the scope	• **Accepted in principle pending further discussions.**	Although there will be no Ministerial Board given implementation of the role of Chief Coroner, it is envisaged that the office will be steered at a high level which could include representatives from local authorities. MoJ agreed to update the Panel once this has been developed further.

	for learning from deaths in custody.		
Cross Sector Learning	**36.** A robust casework management approach to inquests into deaths in custody should be adopted by all coroners, including appropriate use of pre inquest hearings. This should be reflected in upcoming MoJ training events for coroners. These allow for agreement and communication of a timetable that can be regularly reviewed, and calling the investigation bodies to account for delays as well as anticipating complexities that may lead to delay and to manage expectations of the family by communicating the reasons for any delays.	• **Accepted in principle pending further discussions. Accepted in principle pending further discussions.**	MoJ updated the Panel to explain that a current round of training for coroners was addressing the need for appropriate case management. This would also be a relevant topic for the Chief Coroner to issue practice guidance on, if necessary.

Cross Sector Learning	**37.** The MoJ should ensure that training for coroners includes information on managing expectations of families and ensuring they set up a mechanism for providing clear, early information to families about where to go for independent advice and support and the obtaining of legal advice and or representations (including how to apply for funding) so this	• **Accepted in principle pending further discussions.**	The Charter will set out the level of services families should receive in relation to inquests as well as information on what to expect. However, there was no signposting to other sources of advice. There would be information in the Charter about how to complain. The Panel were concerned that this was a complicated process and families would find it difficult to direct their complaint to the appropriate body (which could be the local authority and Local Government Ombudsman or the Office for Judicial Complaints). The Chief Coroner would not have a remit to deliberate on complaints but would want to

	does not create unforeseen delays further into the case.		be informed about the number and outcome. The Chief Coroner's role in complaints would need to be carefully communicated.
Cross Sector Learning	**38.** The MoJ should amend the draft Charter for the coroner service to ensure that coroners' offices review cases more frequently and assess whether they need resources or help from another district to complete death in custody cases more quickly.	• **Recommendation withdrawn**	The Panel discussed this recommendation with MoJ on 16 January – it was agreed that the requirement for contact every three months (or when a change in circumstances could be reported) was realistic for death in custody cases.
Cross Sector Learning & Family Liaison	**39.** Investigation bodies' family liaison protocols and Coroners courts should provide information to bereaved people on how to get advice and support about the inquest process.	• **Accepted in principle pending further discussions.**	Panel to communicate this expectation to PPO, IPCC and coroners' offices. The Panel will raise this in their ongoing discussions about family liaison with custodial sectors and other investigatory bodies in 2012/13.
Ministerial Board on Deaths in Custody – 7 February 2012			
Panel Member	**Recommendation**	**Recommendation Status**	**Details & Update**
Family liaison Deborah Coles	**40.** Trusts with responsibility for detained patients should have procedures in place for ensuring good quality family liaison	• **Accepted**	At the Board meeting, Paul Burstow, Minister of State for Care Services, recognised the importance of positive engagement with families by health providers, especially when things go wrong. He

	with bereaved families. Families should be signposted to independent sources of legal advice, help and bereavement support. Policies on investigation should be explained to families and ensure they are offered an opportunity to be involved, receive ongoing information and have sight of reports.		agreed that Department of Health would follow up our recommendations, initially by including these insights in the National Suicide Prevention Strategy. The Panel will meet Department of Health officials in due course to work out the specific steps that can be taken to implement our recommendations.
Family liaison	**41.** Trusts should keep families informed of actions taken to learn from their relative's death including changes to policies and procedures as a result of the death, investigation or inquest.	• **Accepted**	As above.