IAP Response to Feedback at Consultation Event March 2012 – Read in conjunction with IAP workplan 2012-13

Stakeholder suggestions for further work to be undertaken by the Independent Advisory Panel on Deaths in Custody – taken from feedback following Stakeholder Consultation Event on 2 March 2012

Suggestions for further work by IAP	**IAP workstream/project**	**IAP response**
Provision of medical care whilst in prison (long standing medical condition; asthma, diabetes, epilepsy etc).	• Statistics bulletin 2012	The Panel will consider this as part of its ongoing work to analyse the statistics on natural cause deaths as well as liaison with Offender Health as the NHS Commissioning Board takes on responsibility for national commissioning in this area.
Deaths of people with learning disabilities in custody.	• Equalities	The Panel is developing an equalities project – learning disability will be one of the strands to explore. NOMS commitment to screening prisoners in early days will enable us to identify the prevalence of this factor in deaths in custody.
Women in prison; proportion of black deaths in custody; translation of lessons learned to staff/officers at ground level.	• Equalities • Cross sector learning	The Panel is developing an equalities project which will focus on understanding the evidence around proportionality and deaths in custody of BME offenders. Learning from deaths in custody will continue as project in the Panel's second term – the Panel will look at recommendations to custodial sectors to enable them to put systems in place to ensure all learning can be actioned by operational staff and sustained in the medium and long term.
The value of NHS commissioning without centralised standards i.e. for prison each PCT commissions this should be against a national framework of quality targets and indicators Therefore we should look at setting national medical standards and HCPs should conform to NHS standards as		The Panel continues to engage with Department of Health to understand the role and function of the NHS Commissioning Board. The intention to commission healthcare in prisons on a national basis should complement the idea for minimum standards.

well		
Am worried that work on restraint related deaths has been on the mechanics rather than prevention and learning. Should look at how to reduce conflict and hence need for physical intervention. Second, what the prison service is calling "unclassified" deaths. Third, could look at particular groups of people e.g. women, prisoners on remand, children, natural cause deaths of middle aged men.	• Restraint • Statistics Bulletin 2012 • Equalities	The Panel's draft common principles on the use of restraint cover areas such as how providers include de-escalation and holistic perspectives on reducing conflict as well as learning in their training packages. This could be developed further. NOMS will be reporting, in June 2012, to the Ministerial Board on Deaths in Custody about their review of unclassified deaths. The Panel will take a view on further exploratory work once they have had an opportunity to read the review. Particular groups of prisoners will be covered under scoping of the equalities project – particularly women; young people; people with learning disabilities and BME offenders.
We need to invest in research on: restraint reduction programme including root cause analysis on restraint & near misses; trauma informed care; advanced directives.	• Restraint	The Panel will consider how to incorporate this suggestion into planned work on common principles.
Prison listeners - how much do they reduce risk of self-inflicted deaths; what are the key factors to their effectiveness; how can IAP promote enhancing their role and possibly extending it, e.g. to mental health sectors?		The Panel will consider how to engage with the NOMS Listener Scheme in 2012 – perhaps through a prison visit. The positive difference Listeners make for providing emotional support to prisoners and preventing harm and self-inflicted deaths should be recognised and fully understood.
I would like to see a detailed investigation into the issue of women in prison - it is my personal view that in the majority of cases imprisonment is counter productive and that women	• Equalities	The Panel will be exploring data on self-inflicted and near deaths of women in prison this year.

generally are disproportionately punished compared with men.		
Important for those who apply restraint in custody to not only have first aid training, but also have a basic knowledge of resuscitation techniques, given the potential dangers of the restraint procedure manifesting into a medical emergency.	• Restraint	The Panel will consider whether this should be included in the common principles to ensure commissioners of services require providers to be appropriately trained.
Design of cells to minimise opportunity for self harm. The standard of mental health care and assessment in custody. The provision of high quality clinical reviews conducted independently of the PCT and carried out by the appropriate medical professionals who can critique the care in a thorough manner.	• Mental health • Article 2	There is no work planned on the built environment at present, although the results from research into implementation of coroners' Rule 43 letters shows this is a significant theme and the Panel will highlight this to the custodial sectors in the final report. The Panel will be commissioning a literature review to look at the broad-ranging impact of mental health problems and mental illness on detainees safety and deaths in custody. The Panel continue to pursue recommendations made to PPO and Offender Health about improving timeliness of clinical reviews commissioned from PCTs following deaths in custody.
Assistance in helping develop the role of expert reference group (e.g. The PMVA Partnership) in accrediting restraint training within the NHS. As mentioned, we are setting common standards across NHS training providers, but have a long way to go; we think this is a model the NHS should replicate further.	• Restraint	The Panel has been pleased to engage DH and other NHS colleagues on the use of restraint and common principles project. This will be developed in 2012/13 with specific meetings.
Pull together data from all sectors on	• Restraint	The Panel will undertake a statistical analysis of all deaths in

use of restraint. All sectors already collect this data for their own governance processes. Trends by gender, age, ethnicity, mental health etc. I		custody to update on the publication in 2011. They are also developing suggestion for how police forces could submit use of force data for analysis and learning by a suitable national body – which will be reported to the Ministerial Board.
To think about practical ways in which the IAP information sharing statement can promote sharing across multi-agencies.	• Information flows through the CJS	The Panel is keen to ensure that the information-sharing statement is used by practitioners in all the sectors and that it can be adopted into existing multi-agency arrangements. This could be done by a supporting document explaining how the statement should be used and by whom – to be identified when consulting on statement.
Promoting the responsibilities of psychiatrists to undertake or facilitate physical heath care. Promoting the importance of access to 'the essentials' of physical health for detained patients i.e. good nutrition, exercise, fresh air and meaningful occupation	• Deaths of detained patients • Natural cause deaths	The Panel will continue to pursue recommendations to the Ministerial Board in March 2011 aimed at improving physical healthcare for detained patients and to reduce the number of natural cause deaths in this population.
Deaths & acts of self harm directly after release from custody.		The Panel does not currently have a remit to look at deaths after release although they do refer to available data and studies to inform the whole picture. This is an area for development in the longer term.
I did raise this during the workshop and although not strictly a potential death in custody I do have concerns when people are held in custody at court, be that from Police or from Prison, and those are then released, if they raise concern, either by their demeanour or documented (PER or ACCT Plan),	• Information flows in the CJS	HMIP has agreed to undertake further inspection of PERs in prison. The Panel will check what the expectations are on providers to pass on information about risk of suicide to other agencies in touch with the released detainees (e.g. probation).

there is no laid down practise for concerns to be passed on. Any suicide after release would not strictly be a death in custody however our duty of care should have a structured approach to pass any such concerns on.		
Close work to influence the role of Chief Coroner and communicating this work to the sector. Continuing to act as (and improving work to be) an effective conduit for information across the various custodial sectors which enables shared learning and consistent practice (when it is appropriate). Including DfE on the Ministerial Council	• Cross sector learning	The Chief Coroner, Peter Thornton QC, will be appointed from September 2012. The Panel is arranging an early meeting with the Chief Coroner and will also be pursuing recommendations made in relation to learning from deaths in custody and actions to reduce delays to death in custody inquests. DfE have been invited to attend the June meeting of the Ministerial Board to discuss the process for investigating any future deaths in secure children's homes.